National Library of Medicine

FOUNDED 1836

Bethesda, Md.



U. S. Department of Health, Education, and Welfare

PUBLIC HEALTH SERVICE

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

JANUARY, 1969 • VOLUME 68 • NUMBER 1

W1
MI 223

RECEIVED
JAN 30 1969
National Library of Medicine



Sketch for the Medici Madonna,
Pen and ink by Michelangelo, About 1524

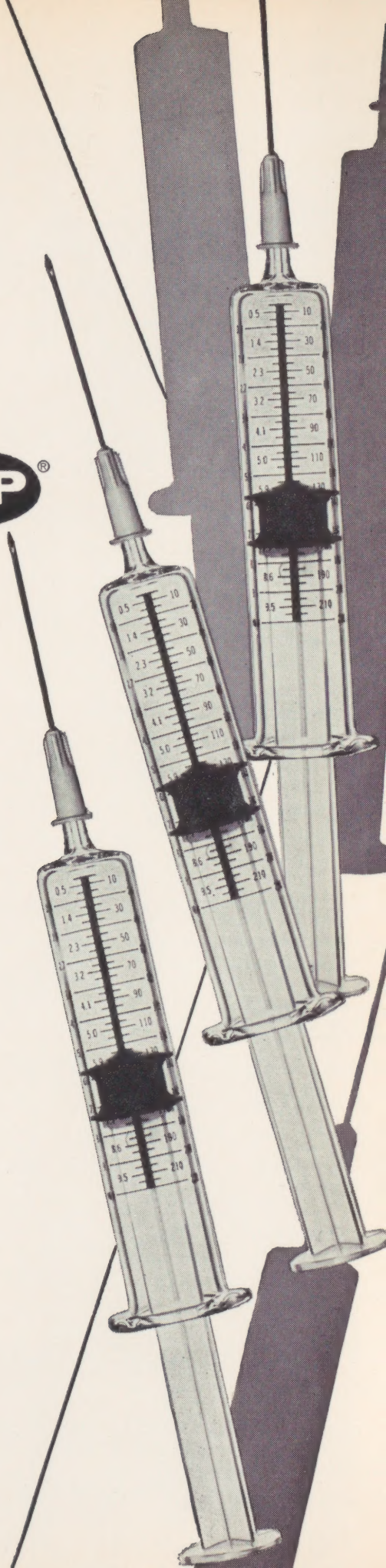
Program on Page 4 for Annual Michigan Conference on Maternal and Perinatal Welfare

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



BROMSULPHALEIN® IN A COMPLETE, STERILE, DISPOSABLE, & ECONOMICAL PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

The BSP Disposable Unit contains a sterile syringe with the dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized BSP solution. Each unit contains complete directions for use, precautions and contraindications.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor — the most costly commodities.

HYNSON, WESTCOTT & DUNNING, INC.

HW&D (BSP03)

BALTIMORE, MARYLAND 21201

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

JANUARY, 1969 • VOLUME 68 • NUMBER 1

Divided Legislature Convenes in Lansing; Democrats to Chair House Committees

BY M. A. RILEY
MSMS LEGISLATIVE COUNCIL

A Democrat-controlled House of Representatives, and a State Senate with reorganized Republican leadership, convened in Lansing Wednesday as Michigan's 75th Legislature. The November 5th election saw the Democratic Party regain the control of the House which it relinquished in 1966; the State Senate did not stand for election and continues with 20 Republicans and 18 Democrats.

Senate Majority Realigned

Top posts, however, remain in the hands of incumbents Sen. Emil Lockwood of St. Louis, majority leader; Sen. Robert VanderLaan of Grand Rapids, majority floor leader, and Sen. Thomas Schweigert of Petoskey, President pro-tem in the absence of the Lieutenant Governor.

Major changes hinged upon the resignation from the Senate of Frank D. Beadle, who had been Chairman of the Senate Appropriations Committee, a coveted post. The new Chairman is Charles Zollar of Benton Harbor. Mr. Zollar's former position as assistant majority floor leader was assumed by Sen. Lorraine Beebe of Dearborn – the first woman in Michigan legislative history to hold such a post.

Sen. Schweigert, who was also Chairman of the Senate State Affairs Committee (which handles most licensing legislation), stepped down from that post. It was filled by Sen. Robert Huber of Troy.

Sen. Milton Zaagman, Grand Rapids, became first lieutenant to Sen. Schweigert and his former responsibility as "majority whip" went to Sen. John Toepp of Cadillac.

Senator Beadle's vacated seat on the powerful Appropriations Committee was filled by Sen. Gary Byker of Hudsonville. Alvin DeGrow of Pigeon, who was elected to replace Mr. Beadle in the Senate, has been assigned to the State Affairs Committee.

House Leadership to Switch

Fifteen new State Representatives will be sworn in for the first time in January. Seven of them



are Democrats who defeated incumbent Republicans, whereas only one newly-elected Republican defeated an incumbent Democrat. The net result is a House of Representatives with 53 Republicans and 57 Democrats.

The switched majority presages a complete change in the House of Representatives organization. Democrats will select a Speaker and name all Committee Chairmen, as well as assuming the majority on all House Committees. Selections for leadership positions in the House were determined in late December and will be announced in full in *"Medigram."* The situation parallels that reported in January of 1967 when the previous November election left a House with 55 members of both Parties and subsequently recounted races left the Republicans a slim margin of control.

BREAKING NEWS
DEADLINE DEC. 20

SEE THE NEW EIGHT-PAGE PHOTO SECTION IN THIS ISSUE, BEGINNING ON PAGE 55

Michigan Doctors to Lead Week-Long Symposium in Guam

Eight Ann Arbor physicians left Sunday for Guam where they will conduct a week-long medical symposium at the invitation of the island's governor, Manual F. L. Guerrero. They will return the first week of February.

The group is led by R. Craig Barlow, M.D., internist at St. Joseph Mercy Hospital in Ann Arbor. Five others making the trip from St. Joseph Mercy Hospital are Philip Hoskins, M.D., radiology; Jerry Gray, M.D., pathology; Robert S. Ideson, II, M.D., emergency room; Richard O. Kraft, M.D., surgeon and John B. Tipton, M.D., plastic surgery.

David H. Middleton, M.D., obstetrics-gynecology, and Jaraslan M. Bandera, M.D., pediatrics, are representing the University of Michigan Medical Center.

In addition to conducting the federally financed symposium the men will advise the Guam physicians on organizing a local medical society and aid them as an affiliate society with the Washtenaw County Medical Society.

Michigan Medicine will publish an account of the doctors' experiences in a later issue.



R. Craig Barlow, M.D., Ann Arbor, pinpoints Guam on the globe. Late this month he will lead a group of eight Ann Arbor physicians — all MSMS members — on an expedition to the Pacific island to conduct a week-long seminar and establish a component medical society.

50,000 Sought By MHC Through Four-Part Plan

The Michigan Health Council hopes to recruit at least 50,000 students into health occupations through a four-part program made possible by a recent grant from the W. K. Kellogg Foundation of Battle Creek.

With the $77,506 grant, the MHC plans to establish an intensive health careers recruitment program in Michigan, provide community colleges and other state educational institutions with data and information concerning health occupations, develop a public information program concerning health careers and serve as a sponsor of special conferences, seminars and meetings concerned with health manpower recruitment.

BUDD NOW DIRECTS NORTHVILLE HOSPITAL

Richard D. Budd, M.D., Livonia, began duties recently as the new medical superintendent at Northville State Hospital.

Arnold, Stuber Lead 1969 MCCC

The Michigan Cancer Coordinating Committee will be headed during 1969 by C. Fred Arnold of Detroit, newly-elected chairman. Roscoe V. Stuber, M.D., Howell, is new vice chairman, and Helen A. Schulte of East Lansing and the MSMS staff, is secretary.

Honorary members are Donald E. Johnson of Flint and Harry M. Nelson, M.D., Detroit.

Committee representatives from various organizations to the committee are:

MSMS — Clifford W. Colwell, M.D., Flint; Daniel L. Rousseau, M.D., Mt. Clemens; Max E. Dodds, M.D., Flint, and Henry J. Vandenberg, Jr., M.D., Detroit

Michigan Cancer Foundation — C. Fred Arnold, Detroit and William Bromme, M.D., Detroit

Michigan Department of Public Health — John Cowan, M.D., Lansing

Michigan State Dental Association — Bernard E. Luck, D.D.S., Lansing

Michigan Health Officers Association — Byron P. Brown, M.D., Charlotte

American Cancer Society, Michigan Division, Inc. — C. Allen Payne, M.D., Grand Rapids; Roscoe V. Stuber, M.D., Howell; Lauren S. Elliott, Flint, and Mrs. Frank C. Painter, Grass Lake.

ALLERGISTS ELECT GOODWIN, LESESNE

Serving as officers of the Michigan Allergy Society for the 1968-1969 year are Jack E. Goodwin, M.D., Saginaw, president; John Lesesne, M.D., Grosse Pointe, president-elect; Leonard L. DiLella, M.D., Birmingham, secretary, and Rudolf Wilhelm, M.D., Dearborn, treasurer.

Mailbag

(Note: By all odds, one of the most popular choices for Michigan's Outstanding Physician Award was Doctor Peebles-Meyers for 1968. To show why and to demonstrate her true qualities as a warm teacher, friend, and physician, we want to share her letter to MSMS. —Brooker L. Masters, M.D., Publication Chairman)

It is very difficult to write to an organization as large as Michigan State Medical Society but I would be very remiss if I made no attempt to express some of my gratitude on paper for the "outstanding physician award" recently conferred. You, of all those concerned, know that the selection came as a complete surprise. In fact, the shock is really just lifting.

As I contemplate what this honor really means, I appreciate the high ideals toward which I must strive each day with unflagging effort. I confess to a bit of fright!

In accepting one of our society's highest honors, I accept not for myself but for the many, many relatives, friends, teachers and associates who have had any part in my development. They are the ones who are truly honored for no one achieves anything by his own efforts.

The expressions of warmth that have poured forth from all segments of the community are too numerous to catalogue. They serve to underline further my continuing obligations.

Please convey my humble thanks to all concerned in my selection. They will never know what joy they have afforded those who love me.

Sincerely yours,

Marjorie Peebles-Meyers, M.D.

Per Patient Day Expenses Up 11.7% in Michigan

MHA RELEASES 1967 FIGURES

It cost over a half billion dollars ($558,718,000) to operate Michigan's 287 hospitals during 1967, according to statistics from H. Allan Barth, executive director of the Michigan Hospital Association.

Mr. Barth said that despite a general decrease in admissions, there was a 13.2% increase in hospital operating expenses in the state's voluntary, short-term general hospitals. Per patient day expenses in these hospitals rose 11.7% from $51.81 in 1966 to $58.69 in 1967.

Total operating expenses for the state's voluntary, short-term general hospitals came to $418,878,000 and revenue from patients and third party payers $403,027,000, leaving a deficit of $15,851,000, based solely on patient revenues against expenditures. The 1967 total revenue figure, which includes grants, gifts, rentals, concessions and other non-patient income sources, was $419,452,000 which gave hospital administrators an actual cash balance of only $574,000 for meeting depreciation of hospital facilities and equipment — a minute .013%.

Statistics from 31 osteopathic hospitals, surveyed by the Michigan Osteopathic Hospital Association, were included in the survey.

ADMISSIONS, BIRTHS DOWN

Other information covered in the Michigan Hospital Association report included:

- Admissions throughout the state decreased from 1,176,681 in 1966 to 1,164,413 in 1967. Non-federal, short-term general and other special hospitals admitted 1,104,094 patients, or 97% of the total admissions figure.
- Births in Michigan continued to decline by 3,103, from 147,197 in 1966 to 144,094 in 1967.
- Payroll continued as the largest single budget item for Michigan's voluntary hospitals, constituting 61.8% as compared to a national average for these hospitals of 60.2%.
- The ratio of full-time hospital employees to patients in Michigan's short-term general hospitals was 271 per 100 patients. This represents an increase of 3 employees per 100 patients over 1966. The national average for these hospitals is 265 employees per 100 patients.
- The average stay of Michigan voluntary hospital patients was 8.3 days, consistent with the national average.

Mr. Barth said the major causes of rising hospital expenses are the constant upward creep of inflation which is gripping the entire nation, the salary and fringe benefit increases which are being given to all hospital employees and the increased costs of materials and equipment which are becoming standard components of good hospital care.

Mrs. Willey Is Renamed by AAMA

Mrs. Betty Lou Willey, Port Huron, has been elected to her third term as speaker of the house of the American Association of Medical Assistants. The election took place during the Association's 12th annual convention held recently in Columbus.

Mrs. Willey has held the offices of president, speaker of the house, recording secretary, treasurer and parliamentarian for the Michigan Association.

The AAMA seeks to increase the education and professionalism of medical assistants.

DAVEY FOLLOWS NOE AS PRESIDENT OF TB ASSOCIATION

The Michigan Tuberculosis and Respiratory Disease Association this year will be led by Winthrop N. Davey, M.D., Professor of Internal Medicine, University of Michigan Medical School. Lester Kirk, of Detroit, was elected first vice-president; Walter A. Meier, M.D., of Monroe, second vice-president; Mrs. George A. Ziegler, of East Lansing, secretary; and John R. Pettibone, of Lansing, treasurer.

Among board members elected at the Jackson annual meeting were Ophelia Baker, M.D., West Branch; G. L. Brinkman, M.D., Detroit; Byron P. Brown, M.D., Charlotte; James A. McLean, M.D., Ann Arbor; and Walter A. Meier, M.D., Monroe.

Betty Grundy, M.D., Saginaw, was chosen by the affiliated Saginaw association as a trustee.

TAYLOR, MEDLAR, MRS. STONE RECEIVE JACKSON AWARDS

Two physicians and a doctor's wife were honored at the first Jackson County Medical Society Awards Night. Cited were Ross V. Taylor, M.D., chairman of the MSMS Council, for contributions to the medical profession at local, state and national levels; Robert E. Medlar, M.D., for community activities such as president of the Jackson school board and chairman of the Jackson Area Drug Abuse Council, and to Mrs. Ethon L. Stone, for her outstanding work with the health careers information program for the Auxiliary.

Mrs. Guy Directs State Nurses

The Michigan Nurses Association has announced several personnel changes. Joan S. Guy, R.N., has assumed the duties of Executive Director of MNA after six years as assistant director. Former Executive Director Eleanor M. Tromp, R.N., will serve as director of the Michigan Nurses Economic Security Organization.

Eight Speakers Scheduled For Maternal Welfare Meeting

Eight speakers are planned for the Eighth Annual Michigan Conference on Maternal and Perinatal Welfare set March 26-27 in Flint.

They are:

Bradley E. Smith, M.D., *associate professor, department of anesthesiology, University of Mimai, Fla.* — "Analgesics, Anesthetics, Potentiators Used — Pre and Intra Partum";

Robert D. Visscher, M.D., *senior attending physician, Blodgett Memorial Hospital, co-director of education in research, obstetrics-gynecology, St. Mary's Hospital, Grand Rapids* — "Who Should Receive Rh Immune Globulin?";

Herbert S. Kupperman, M.D., Ph.D., *associate professor of medicine, department of therapeutics, New York University Medical Center* — "Hormone Levels and Significance During Pregnancy";

Alan F. Guttmacher, M.D., *president, Planned Parenthood-World Population* — "Sex Education and Family Planning";

John W. Huffman, M.D., *Children's Memorial Hospital, Chicago* — subject of his choice;

John W. Goldzieher, M.D., *San Antonio, Tex.* — "Side Effects, Complications and Dangers relative to Newer Contraceptive Agents";

Colin Campbell, M.D., *associate professor of obstetrics-gynecology, University Hospital, Ann Arbor* — "Amniotic Fluid Analysis and the Intrauterine Transfusion in the Management of Erythroblastosis Fetalis";

Unnamed — "Pros and Cons, Administration, Advantages of the Central Premature Nursery and Computer Control."

Jack W. Thompson, M.D., is chairman of the 1969 conference.

The first in a series of "dinners with the legislators" was staged at MSMS headquarters recently by the Washtenaw County Medical Society, who met with the full complement of their state representatives for an evening of reports and discussions. Otto K. Engelke, M.D., second from left, chairman of the MSMS Legal Affairs Committee, was also present. Others who attended, from left, are Fred Holtz, M.D., Reps. Roy Smith of Ypsilanti, Thomas G. Sharpe of Howell and Raymond J. Smit of Ann Arbor; R. Craig Barlow, M.D., chairman of the Washtenaw County Legislative Committee and Edwin H. Place, M.D., Washtenaw County Society president.





JAMES J. LIGHTBODY, M.D.
PRESIDENT, 1968-69

Joint Efforts Tackle Medical Manpower Needs

The increasing interest in Medical Manpower has been stimulated namely through the activities of the Michigan State Medical Society and the American Medical Association. Doctor Robert Mason, President-elect of the Michigan State Medical Society and Doctor Milford Rouse, immediate Past-President of the American Medical Association, have been spearheading the drive here in Michigan to get the interest and cooperation of individuals and organizations who are not directly associated with the practice of Medicine.

It is obvious that a shortage of doctors and others who are part of the health team affects all consumers. Everyone should be interested in knowing where the shortages of Medical Manpower are and what can be done in the future to alleviate the ever worsening situation.

The first major shortage of Medical Manpower is in the physician category, and the Michigan State Medical Society is on record as recommending that Michigan State University be given the funds to expand a two-year medical curriculum into a regular four-year medical school. This would graduate approximately one hundred more physicians annually. We have also suggested that funds be made available to both the University of Michigan Medical School and the Wayne State University Medical School to increase their number of annual medical student admissions.

The shortage of physicians, however, is just one of the areas where we should direct our attention. There are shortages of all Allied Health Personnel, particularly registered and practical nurses, physical therapists, occupational therapists, laboratory and X-ray technicians, dieticians and many other categories which are so essential to the hospital care and the after-hospital care of patients.

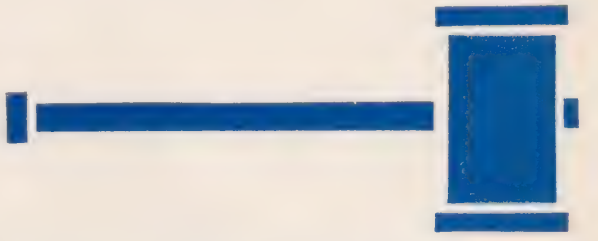
Doctor Milford Rouse, at the Michigan Manpower Conference in Battle Creek, suggested that we should sponsor health career counselling programs in every community and he also suggested that we should encourage those students now enrolled in many colleges and universities to complete their studies in medical careers and perhaps in so doing help to cut the high dropout rate in colleges. Greater effort should be made by our organized health groups to contact high school students and tell them of the advantages of being on the very important health team. This type of contact may interest more high school students in going into medicine and thereby increasing the applicants to medical schools.

A Citizens' Committee on Medical Manpower has been authorized and will include leaders in the fields of business, industry, government, labor, agriculture, education and community services.

It would be well to consider methods to alert the young people in the Negro and other minority groups concerning the advantages of health careers.

This type of coordinated interest by a large number of professional and lay groups will help to solve the medical manpower dilemma.

James J. Lightbody, M.D.



PRESIDENT'S PAGE



He is elderly, he is on corticosteroids, when he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given the drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company
Pearl River, New York

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

2. Submit original, double-spaced typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by Michigan Medicine. Michigan Medicine will pay the first $25 of the engraving bill, and the authors shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.

6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.

7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

8. Articles should ordinarily be less than four printed pages in length (3000 words).

9. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

10. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

IN THIS ISSUE

SCIENTIFIC ARTICLES

31 Lower Lung Field Tuberculosis; Ma. Zenaida Fernandez, M.D., Edward G. Nedwicki, M.D.

36 Use of Cholesterol Kits

37 Mammography and Xeroradiography; John N. Wolfe, M.D.

39 Early Management of Facial Nerve Trauma; Roger Boles, M.D.

45 Treatment of Hypercalcemia; Joseph J. Weiss, M.D., Jose Yanez, M.D.

49 More Drugs Mean More Problems In Managing Diabetes Mellitus; John B. Bryan, M.D.

SPECIAL ARTICLES

72 Explanation of Michigan Blue Shield Variable Fee Payment Mechanism; Louis F. Hayes, M.D., Neal L. McCue

EDITORIAL VIEWS

21 Doctor, Take More Time With Patient; Brock E. Brush, M.D.

21 Medical Students Today, Society Members When?

OTHER FEATURES

1 Hot News

5 President's Page

9 Officers, Editors

12 Our State Society

22 Socio-Economic

24 Legislation

55 Photo Section

70 MSMS Members in the News

80 In Memoriam

84 Notes and Quotes

Michigan Medicine

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at Lansing, Michigan. Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351.

© 1969 Michigan State Medical Society.

An open letter to you from Michigan Blue Shield...

Blue Shield of MICHIGAN

MICHIGAN MEDICAL SERVICE • 441 E. JEFFERSON AVE. • DETROIT, MICHIGAN 48226

Dear Doctor:

Like all busy men, you probably find it difficult to keep up with everything that's going on in today's changing world, perhaps even in your own specialty.

At Blue Shield we have several ways in which we try to keep you informed, but we know that despite our best effort, you may have questions about what we do and how or why we do it.

Maybe you find a certain billing procedure puzzling, or you have a question concerning our new Michigan Variable Fee plan, MVF. Maybe you'd simply like to invite our comment on a Blue Shield philosophy of operation.

So please drop us a line if you have a question. We'll guarantee a prompt reply, and we'll do our best to help you.

After all, that's our business.

John M. Wellman

John M. Wellman, M.D. Chairman of the Board

John C. McCabe

John C. McCabe, President



Michigan Medicine

MICHIGAN STATE MEDICAL SOCIETY

120 West Saginaw (P.O. Box 152)
East Lansing, Mich. 48823
Area Code 517, 337-1351

1010 Antietam Road
Detroit 48207
Area Code 313, 965-0541

OFFICERS OF THE SOCIETY, 1968-69

PRESIDENT..... James J. Lightbody, M.D.....Detroit
PRESIDENT-ELECT.. Robert J. Mason, M.D.....Birmingham
SECRETARY..... Kenneth H. Johnson, M.D.....Lansing
TREASURER..... John R. Ylvisaker, M.D.....Pontiac
SPEAKER..... James B. Blodgett, M.D.....Detroit
VICE-SPEAKER.....Vernon V. Bass, M.D.....Saginaw
PAST PRESIDENT....Bradley M. Harris, M.D.....Ypsilanti

THE COUNCIL

CHAIRMAN.....Ross V. Taylor, M.D.....Jackson
VICE-CHAIRMAN....Ralph R. Cooper, M.D.....Detroit
SECRETARY..... Kenneth H. Johnson, M.D.....Lansing
TREASURER.....John R. Ylvisaker, M.D.....Pontiac

Sidney Adler, M.D.....1st.....Detroit
Ralph R. Cooper, M.D.....1st.....Detroit
Don W. McLean, M.D.....1st.....Detroit
Milton R. Weed, M.D.....1st.....Grosse Pointe Park
Robert K. Whiteley, M.D.....1st.....Detroit
Ross V. Taylor, M.D.....2nd.....Jackson
Harvey C. Jansen, M.D.....3rd.....Battle Creek
Don Marshall, M.D.....4th.....Kalamazoo
John R. Pedden, M.D.....5th.....Grand Rapids
Harold H. Hiscock, M.D.....6th.....Flint
John J. Coury, M.D.....7th.....Port Huron
A. Carl Stander, M.D.....8th.....Saginaw
Robert V. Daugharty, M.D.....9th.....Cadillac
Edward H. Rodda, M.D.....10th.....Bay City
Brooker L. Masters,.....11th.....Fremont
Wm. A. LeMire, M.D.....12th.....Escanaba
J. Robert Franck, Jr., M.D.....13th.....Wakefield
Harold F. Falls, M.D.....14th.....Ann Arbor
Sydney Scher, M.D.....15th.....Mt. Clemens

EXECUTIVE DIRECTOR...Hugh W. Brenneman East Lansing
ASSOCIATE EX. DIR..... Warren F. Tryloff....East Lansing
GENERAL COUNSEL.....Lester P. Dodd.....Detroit
LEGAL COUNSEL.....A. Stewart Kerr.....Detroit
ECONOMIC CONSULTANT Clyde T. Hardwick.....Detroit

SCIENTIFIC EDITOR
John W. Moses, M.D., Detroit

EXECUTIVE EDITOR
Herbert A. Auer

MANAGING EDITOR
Judith Marr

ASSOCIATE SCIENTIFIC EDITORS
Frederick J. Cady, Jr., M.D., Surgery
Saginaw
Robert M. Daugherty, M.D., Basic Science
East Lansing
Harold E. De Pree, M.D., Medicine
Kalamazoo
Dean C. Elliott, M.D., Otolaryngology
Petoskey
Tommy N. Evans, M.D., Obst.-Gyn.
Detroit
Dorin L. Hinerman, M.D., Pathology
Ann Arbor
Samuel D. Jacobson, M.D., Medicine
Detroit
Benjamin Jeffries, M.D., Psychiatry
Detroit
Raymond S. Kurtzman, M.D., Radiology
Detroit
A. Martin Lerner, M.D., Medicine
Detroit
George H. Lowrey, M.D., Pediatrics
Ann Arbor
Carl A. Moyer, M.D., Surgery
East Lansing
Charles E. Parkinson, M.D., Radiology
Battle Creek
John C. Pierce, M.D., Medicine
Grand Rapids
Frank H. Power, M.D., Surgery
Traverse City
J. G. Turcotte, M.D., Surgery
Ann Arbor
Alexander J. Walt, M.D., Surgery
Detroit
Park W. Willis, III, M.D., Medicine
Ann Arbor
Richard E. Wunsch, M.D., Medicine
Traverse City

Publication Committee

Brooker L. Masters, M.D.
Harvey C. Hansen, M.D.
William A. LeMire, M.D.
Don Marshall, M.D.
Don W. McLean, M.D.
Edward H. Rodda, M.D.
Milton R. Weed, M.D.

So he'll breathe easier:

relieve anxiety while you relieve pain.

Relief of pain is usually a major goal in traumatic conditions. But often of importance, too, is alleviation of anxiety and tension that may heighten patient discomfort.

Single-prescription, non-narcotic Equagesic may effectively relieve pain. *And* ease anxiety and tension.

TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth®

IN BRIEF.

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

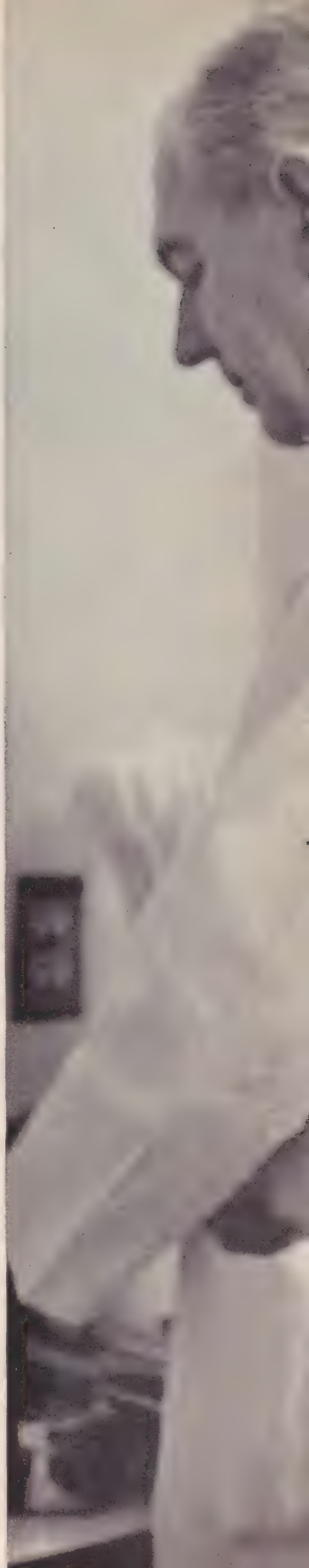
Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.





U-M, MARMP Begin Study of Continuing Study by Doctors

How do physicians keep abreast of the ever-increasing body of new medical knowledge?

To what extent do present continuing education programs meet your professional needs?

What are some of your attitudes toward continuing education programs, and how do such attitudes affect your participation and learning in those programs?

The Center for Research on Utilization of Scientific Knowledge in collaboration with the Department of Postgraduate Medicine at the University of Michigan is currently designing a study which will answer questions such as these. This study will be financed by the Michigan Association for Regional Medical Programs.

A representative random sample of physicians practicing in six geographical regions throughout the state will be asked to participate in the study. Each physician practicing in the state has about one chance in five of being included in the sample.

The research team of physicians and social scientists are enthusiastic about the survey. They expect that the findings will be helpful to all physicians concerned with keeping up to date. In order to yield information that is generally applicable to all physicians in the state, it is important that each person selected in the sample fill out the questionnaire.

"Not only will your cooperation be appreciated, it is crucial to the study," point out the CRUSK officials.



For Your Library

Copies of "A Century of Service in Medicine," published as a Centennial highlight by MSMS, are still available for cost, $2.00. The book, bound handsomely in blue, was written by Wm. J. Stapleton, Jr., M.D., of Detroit, the MSMS Historian. To obtain a copy, write to MSMS, 120 West Saginaw, East Lansing, and enclose a check.



OUR STATE SOCIETY

Michigan Mediscene

Jan. 17-18 — 17th Annual WSU Symposium on Blood, McGregor Memorial Conference Center, Detroit

Jan. 20-24 — Michigan Cancer Foundation and American College of Physicians, "The Internist and Total Cancer Care," McGregor Memorial Center, Wayne State University, Detroit

Jan. 29 — The Council, MSMS Headquarters, East Lansing

Jan. 30 — State Woman's Auxiliary to MSMS, Board of Directors, MSMS Headquarters, East Lansing

Feb. 3-10 — Childrens Dental Health Week

March 12 — The Council, MSMS Headquarters, East Lansing

March 20 — Second Annual Cancer Conference for Nurses, Michigan Division American Cancer Society, Rackham Building, University of Michigan

March 26-27 — Eighth Annual Michigan Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

March 28-29 — AMA 3rd National Conference on Socio-Economics of Health Care, Palmer House, Chicago

April 30 — The Council, MSMS Headquarters, East Lansing

May 7-9 — Michigan Public Health Association Annual Meeting, Pick-Durant Hotel, Flint

May 21 — Annual Muscle Symposium, Wayne County Medical Society Auditorium, Detroit

May 22-23 — Maternal Health Conference, Gull Lake

June 4 — The Council, MSMS Headquarters, East Lansing

July 13-17 — AMA Annual Meeting, New York City

July 31-Aug. 2 — MSMS Midsummer Session of The Council, Boyne Mountain Lodge, Boyne Falls

Sept. 28 — The Council, Sheraton-Cadillac Hotel, Detroit

Sept. 28-Oct. 3 — Michigan State Medical Society Annual Session, Sheraton-Cadillac Hotel, Detroit

See next page for prescribing informatio



You've made it one of your specifics in acute otitis media

DECLOMYCIN
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specifics in acute otitis media

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, the most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strains may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged action permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity, onycholysis and discoloration of the nails (rare). Kidney—rise in BUN apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl. 398-

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

No two women are quite alike...





and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680



Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A·H·ROBINS

in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®
(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)
up to 10-12 hours clear breathing on one tablet





heavenly relief
for unearthly cough

Benylin®
EXPECTORANT

Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

Doctor, Take More Time with Patient

BY BROCK E. BRUSH, M.D., CHAIRMAN
MSMS PUBLIC RELATIONS COMMITTEE

A recent Harris survey published in *Newsweek* reveals that the public places more confidence in doctors of medicine than in any other professional group. Physicians rate substantially higher than Supreme Court justices and clergymen, for example.

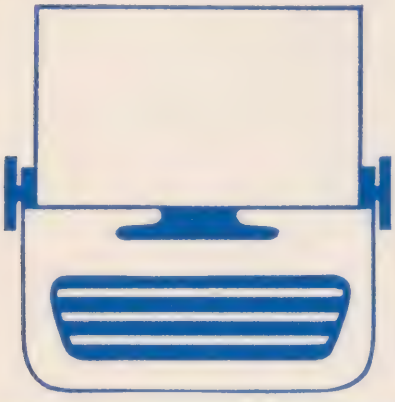
But these findings also point up an alarming paradox: the M.D. today appears to be a favorite target, the subject of numerous printed and spoken charges.

Doctors as a group, it seems, take on a different public image than the physician as an individual. The medical profession seems to have more critics than any other professional group, even though the individual doctor ranks high in the estimation of his patient.

This underscores an old but still sound lesson. Our profession's best public relations instrument is not an expensive agency effort. It is simply the conduct of each of us as an individual, every day with our patients, neighbors, and associates.

Computers and copywriters might offer solutions to refurbish our public image. Nothing — not even the counsel of Madison Avenue's highest-priced public relations man — can speak more eloquently than the individual doctor's attitudes and actions.

The oft-proven way to improve doctor-patient relationships is for the physician to spend just a little more time with each patient and to give a little fuller explanation of the symptoms; and perhaps the fees, too.



EDITORIAL VIEWS

Medical Students Today, Society Members When?

(Editor's Note: The following is excerpted from a recent American Medical Association PR Doctor publication. Attention is called to a special article about MSMS activities with medical students on Page 55).

It is axiomatic that the strength of any organization comes from the collective contributions of its members. It is equally true, however, that a progressive membership is never stagnant, but relies on the infusion of new energies to replace ebbing strengths of yesterday's leaders.

The wellspring of this energy is found, of course, in the nation's medical schools where the students in a few years may — or may not — be the future replenishments for a vibrant medical society, serving both the community and the profession.

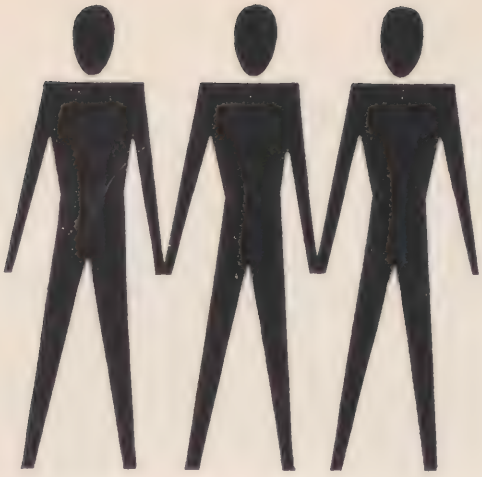
Channeling these future physicians toward society membership as an indispensable concomitant of medical practice, however, is no longer left by thinking societies to a chance, meandering course. The tide of future graduates will inevitably crest at the society's door, but indifference to the continuing stream of today's students may make them indifferent members in the years ahead.

While medical society memberships are on the increase, reflecting general population trends, there are sometimes pitfalls in large numbers. Unless the society is made cohesive through dynamic leadership, stimulating programs, and valuable services, it tends to become an organization of anonymous faces who are wont to "let George do it."

Sustaining *esprit de corps* is essential among contemporary members; but instilling it among the initiates and future members is also a challenge many farsighted societies are now contemplating.

This contemplation of the future inescapably encompasses the students now studying medicine. With the great number of professional organizations now competing for physicians' interests and primary loyalties, alert medical societies are already making their bids and, in the modern complex of expanding medical education, they are making them to the students.

An aggressive medical society can extend a persuasive invitation to the loyalty of these medical students now by offering to them many of the services available to member physicians.



SOCIO-ECONOMIC

Redefine Some Aspects Of Medicare Services

The Social Security Administration recently announced a new definition of part time and intermittent services that may be performed by home health aides for Medicare beneficiaries.

Under the new definition, services performed by a home health aide now can include grocery shopping and light cleaning such as laundering deemed essential for the comfort and cleanliness of the patient. If these household services are incidental to and do not substantially increase time spent by the aide, the cost of the entire visit is reimbursable.

Also revised is the definition of what constitutes a patient's confinement to a home. An individual does not have to be bedridden to be considered to be confined to his home, but leaving his home must require a taxing and considerable effort. A patient may now be considered homebound if absences from his home are infrequent or are periods of a relatively short duration.

The new definition in its entirety reads: "It is expected that in most instances absences from the home which occur will be for the purpose of receiving medical treatment. However, occasional absences from the home for non-medical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, would not necessitate a finding that the individual is not homebound so long as they are undertaken on an infrequent basis or of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home."

24-44 Age Group In State to Grow Fastest, 1965-85

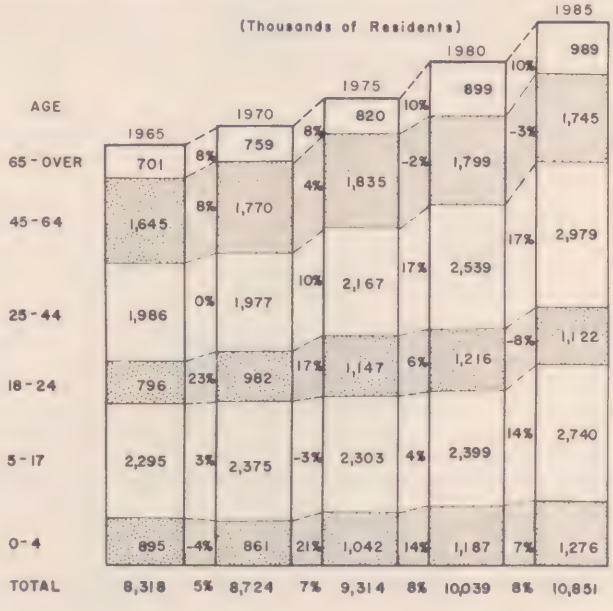
Michigan's projected population growth is changing in the size of the various age groupings, so reports the U.S. Department of Commerce, Bureau of the Census.

The accompanying chart depicts the changing age structure over the period from 1965 to 1985. It is estimated the population will increase 30%, with the 25-44 age category growing the fastest at 50%, while the 45-64 age bracket will remain relatively constant by increasing just 6%.

These changes will create additional demands on our economy to fulfill the varying needs of the people. Housing must grow to meet the specific requirements of retirees as well as family-formers; services, both personal and public, will have to match; recreational facilities should be developed and diversified in a way to satisfy both "grandma" and the "teenage swinger."

Employment availability needs to expand to accommodate the growing size of the 18-84 age group. Educational demands will vary during this period between K-8, high school, and college requirements; and, finally, our senior citizens will require additional medical care and increased social security benefits in line with the 41% growth of this group.

Michigan's changing AGE structure



Weigh these clinical observations on formula feeding for prematures



As you know, the primary goal of premature infant feeding is getting normal growth and development established as quickly as possible. The Gerber Baby Formula ...Modilac,™ (34 calories/fl. oz.) did this faster than any of the other formulas in Keitel and Chu's study.* Infants who weighed 2,000 gm. or less at birth actually gained weight faster than the *in utero* rate of normal infants. And more important this was normal development!



This study demonstrated that prematures on concentrated Gerber Baby Formula (34 calories/fl. oz.) achieved lean body weight as well as rapid weight gain. Edema or fat did not account for the increased weight in the infants.

The Gerber Baby Formula...a complete milk formula, comes in 13 fluid ounce cans. Undiluted, the Gerber Baby Formula provides 40 calories per fluid ounce. In normal (1:1) dilution formula provides 20 calories per fluid ounce.

To obtain 34 calories/fl. oz. add 2.3 fl. oz. of water to one 13 oz. can.

*Keitel, H. G. and Chu, E., Premature Infant Feeding I. The Clinical Usefulness of Caloric Concentration of Formulas, of Early versus Late Feedings and of Low Stearic Acid Content Formulas: The Pediatric Clinics of North America 12: 309 (May) 1965.

"Tomorrow in Today's Hands"
... through Gerber Research.

Gerber®

Gerber Products Company, Fremont, Mich. 49412

Third Article Explains More New Michigan Laws re Health

Vision Tests

Public Act 282 (House Bill 2152) requires a parent or guardian of each enrolling child to submit a statement signed by a district, county or city health department director certifying that the child has passed the Department of Public Health pre-school vision screening test, or a statement signed by a licensed medical, or osteopathic physician or optometrist that the child has had an eye examination during the pre-school years after age three and prior to initial entrance. Neither test will be required if a parent or guardian submits a statement that the child cannot be submitted to such tests because of religious convictions. The State Public Health Director will appoint an equal number of ophthalmologists and optometrists to an advisory board to advise and assist the Director with vision programs. The act becomes effective September 1, 1970.

Inquests

Public Act 274 (House Bill 2780) adds municipal court judges to those authorized to hold inquests upon the written order of the prosecuting attorney, the attorney general or upon the filing of a petition signed by six electors of a county. Inquests shall be held in the same manner as provided by law for the holding of an inquest by a coroner. This act became effective November 15, 1968.



LEGISLATION

Caro State Hospital

Public Act 121 (House Bill 3686) changes Caro State Hospital to a home and training school for the mentally handicapped. Effective November 15, 1968.

Ambulance Drivers, Attendants

Public Act 258 (House Bill 2946) provides for the licensing and regulation of ambulances and drivers and attendants by the Department of Public Health. The Act also authorizes cities, townships, villages and counties to contract for ambulance and inhalator services from private persons. This Bill was strongly supported by MSMS. Effective July 1, 1969.

Hospital Licensing

Public Act 17 (Senate Bill 16) requires that the State Director of Public Health establish a comprehensive system of licensing for *all* hospitals in Michigan. A twelve-member State Health Facilities Council is established within the Department of Public Health to advise and consult with the Director in carrying out the provisions of this Act. Council members are to be appointed by the Governor with the advice and consent of the Senate. The Act also provides that the Director seek advice and consultation from professional organizations concerned with the operation and use of hospitals and after seeking advice and consultation and obtaining concurrence from the State Health Facilities Council, the Director shall adopt and enforce such standards, rules and regulations as are necessary to accomplish the purpose of this act. The Act also defines the powers and duties of the Department. This Act became effective November 15, 1968.

Alcoholics

Public Act 107 (Senate Bill 336) provides that an additional 5% may be appropriated to a spe-

(Editor's Note: Previous issues of **Michigan Medicine** described House-Senate bills which passed the 1968 Legislature and were given immediate effect. The following article concludes this legislative series with brief descriptions of bills that became effective 90 days after adjournment on August 16, 1968 or have a designated effective date. Copies of these laws are available by writing MSMS, 120 W. Saginaw, East Lansing, 48823.)

cial fund to provide continuing support for established, approved alcoholism programs as prescribed by law. Previously, 5% of the proceeds of retailers' license fees collected was to be credited to a special fund for the purpose of promoting and sustaining programs for the prevention, rehabilitation, care and treatment of alcoholics. The Act extends the terms of the present Liquor Control Commission members from 3 to 4 years and authorizes the Legislature to set Commission members' salaries. This Act became effective November 15, 1968.

Sex Education

Public Act 44 (Senate Bill 925) provides that any school district in the State may engage competent instructors and provides facilities and equipment for instruction in sex education. Another bill (Senate Bill 416) to permit instruction in birth control information passed the Legislature but was subsequently vetoed. A written request by parent or guardian shall excuse a student from attening sex education classes with no penalties as to credits or graduation. The Department of Education shall aid in the establishment of implementation of such education. This Act became law on May 23, 1968 without the Governor's signature.

Basic Science Examinations

Public Act 54 (Senate Bill 1079) authorizes the State Board of Examiners, in Basic Science, to accept results of examinations given by national boards if substantially equal to those required in Michigan. Does not apply to any person matriculated in any medical, osteopathic or chiropractic school or college on or before October 15, 1937. Raises the fee for taking the basic science examination for the practice of healing to $25.00. Effective November 15, 1968.

Medical Malpractice

Public Act 172 (Senate Bill 1273) provides that anyone who practices medicine or surgery, or publically advertises that he is able to treat and cure human ailments without a license is guilty of a felony. Formerly, such a person was guilty only of a misdemeanor. Effective November 15, 1968.

Ionia State Hospital

Public Act 48 (Senate Bill 997) extends the term of the special probate judge assigned to hear cases on the release or further commitment of persons confined at the Ionia State Hospital from December 31, 1968 to June 30, 1969. Effective May 28, 1968.

Mentally Deranged Convicts

Public Act 306 (Senate Bill 1296) provides that before releasing any person convicted of crime of violence, where there is a previous history of severe mental derangement, the State Mental Health Department must petition the probate court from which the person was sentenced for an order requiring the prisoner to undergo a clinical mental evaluation at the Center for Forensic Psychiatry. Upon court testimony of two licensed psychiatrists that the prisoner would present a probable hazard to the public, the court shall commit the individual to the Department of Mental Health. Effective November 15, 1968.

New System Explained For Selecting Jurors

BY MICHIGAN PRESS ASSOCIATION

A new system for selecting citizens for jury duty went into effect January 1. More people will be called to serve, but the length of service is cut from three months to a maximum of 30 days.

Prospective jurors are presently selected by township supervisors and city aldermen from property tax roles. They serve for $15 per day. The selection method was designed when Michigan was primarily an agricultural state.

The new law specifies that voter registration lists be used instead of property tax roles. A special jury board, appointed by the governor, will make the selection rather than supervisors and aldermen. A special mathematical formula will insure names being picked at random.

Exemptions under the new law are few: physical or mental disability, persons over 70, police officers and lawyers, citizens who do not understand the English language. The presiding judge may make other exceptions, but excusals are expected only rarely under the new system.

New jurors will be selected by the jury board in May of each year. If lawyers agree, six-member juries may be used for civil cases. In the past, 12-member juries were required for all circuit court cases. Six-member juries will be used for both civil and criminal cases in the new District Courts which replace the present Justice Court system January 1.

A special provision in the new law makes an employer who fires a person because of his absence for jury duty guilty of a misdemeanor.



Geigy



Regroton®

chlorthalidone 50 mg.
reserpine 0.25 mg.

One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Regroton produces a smooth, long-acting effect that usually reduces both systolic and diastolic pressures. At the same time it often acts to allay anxiety and nervous tension associated with hypertension.

Although Regroton is generally well tolerated, adverse reactions may occur. This drug is contraindicated in mental depression, demonstrated hypersensitivity, and most cases of severe renal or hepatic diseases. For a complete list of side effects, please see the Prescribing Information summarized on the following page.

Regroton®

chlorthalidone 50 mg.
reserpine 0.25 mg.



One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. **Precautions:** Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-0225

Newspapers Help To Fight Quackery

Educational efforts to help protect Michigan residents against health quackery are being continued by MSMS.

A recent MSMS newspaper release suggested five questions that every resident should ask as guidelines toward spotting quacks. The release quoted MSMS President James J. Lightbody, M.D., who also serves as medical director of the Michigan unit of the arthritis foundation.

The article appeared in many papers. Typical headlines included:

St. Johns News: "Answers to Six Questions Can Help You Duck the Medical Quack."

Pigeon Progress-Advance: "Questions Can Avoid Health Fraud."

Parma News: "Clues Can Help Spot Health Quacks."

Whitehall Forum: "Test Will Disclose Quack Cures, Gadgets."

Stockbridge Town Crier: "Be Wary of Medical Cures."

Jackson Citizen-Patriot: "America's Health Services Industry Ill."

Detroit News: "Osteopaths Go It Alone; At What Cost?"

Grand Rapids Press: "Doctor Cites State Need; Medical School Shortage Is Critical."

Associated Press: "State Short on Doctors."

Battle Creek Enquirer and News: "Medical Manpower Solution Offered."

Lansing State Journal: "MDs Propel MSU Medical School."

Traverse City Record-Eagle: "Statistics Show Shortage of Physicians in State."

Mt. Pleasant Times-News: "Western Michigan Needs 270 More Doctors, Manpower Study Reveals."

Saginaw News: "School Expansion Is MSMS Physician Shortage Remedy."

Flint Journal: "Medical Official Urges Expansion of Schools."

Michigan Chronicle: "More Medics Are Needed in Michigan."

Pontiac Press: "State MDs OK Plan for DO Option."

Bay City Times: "Osteopathic School Aid Outlook Dim."

Saginaw News: "Osteopaths May Start Building, State Fund Aid in Doubt."

Grand Rapids Press: AMA Chief Hails Dual School Plan."

ANNUAL CLINICAL CONFERENCE

Chicago Medical Society
March 2, 3, 4 and 5, 1969
Palmer House, Chicago

Lectures
Medical Color Telecasts
Teaching Demonstrations
Trauma Conference
Instructional Courses

The CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.





Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg.
A. H. Robins Company, Richmond, Virginia 23220

A·H·ROBINS

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (*see* Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

900134

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

Lower Lung Field Tuberculosis

By Ma. Zenaida Fernandez, M.D.
Zamboanga City, The Philippines
Edward G. Nedwicki, M.D.
Allen Park

Introduction

Pulmonary tuberculosis is well known to cause infiltrates in the upper lung fields, but awareness of involvement of lower lung fields is not so widespread. Tuberculosis of the lower lung fields was described as early as 1886 by Kidd[1] and again in 1888 by Fowler.[2] Since the 1920's, reports have appeared from time to time entitled "Basal Tuberculosis,"[3] "Hilar Tuberculosis,"[4] "Perihilar Tuberculosis" and "Lower Lobe Tuberculosis."[5,9]

More recently the commonly used term has been "Lower Lung Field Tuberculosis."[10, 12]

According to Romendick, et al,[11] the incidence of lower lung field tuberculosis may vary from 0.003 per cent to 18.3 per cent of cases. Reisner[13] reported an incidence of 0.8 per cent among sanatorium admissions. The highest incidence recorded in the literature is 31.5 per cent,[4] the majority of reports are in the range of 2 to 3 per cent.[6,8,9,10,14] Due to this relatively low incidence, the diagnosis can easily be missed in a general hospital, as in the case which is briefly presented below.

Case Report

A 42-year-old, white male was admitted to the Veterans Administration Hospital, Allen Park, Michigan on August 10, 1967 as a transfer from a tuberculosis sanatorium.

He had first become acutely ill in the latter part of July 1966, with productive cough, fever, chills and malaise. A diagnosis of pneumonia was made and the patient was admitted to a hospital on August 2, 1966. Chest roentgenogram on admission showed an extensive, productive type of infiltration in the left lower lobe, with two large cavities near the left hilum (**Figure 1a**). The patient was treated for lung abscess with antibiotics. There was little improvement and on August 20, 1966, a left lower lobectomy was performed.

Postoperatively, the patient became critically ill and follow-up roentgenograms showed extension of the productive infiltrate into the left upper lung field (**Figure 1b**). Pulmonary tuberculosis was considered and sputum examination for M. tuberculosis was positive. Steroids and anti-tuberculosis chemotherapy were instituted and the patient gradually improved. On October 10, 1966 he was transferred to a local tuberculosis sanatorium, where serial roentgenograms showed a persistent pneumothorax on the left. Eighteen days later, he was transferred to another hospital, where attempts to correct the pneumothorax by re-intubation were unsuccessful. He was returned to the sanatorium on December 19, 1966 and remained there until admission to the VA hospital. The pneumothorax spontaneously decreased and after an additional five and one half months hospitalization, the patient was discharged with maximum

Doctor Fernandez was associated with the Department of Medicine at Harper Hospital, Detroit 48201 until her recent change of address. Doctor Nedwicki is an Assistant Professor of Medicine, Wayne State University School of Medicine, Detroit; and is Chief, Pulmonary Disease Section, Veterans Administration Hospital at Allen Park 48101. Please write Doctor Nedwicki for reprints.

This article by Doctors Fernandez and Nedwicki about "Lower Lung Field Tuberculosis" was awarded first prize in the Harper Hospital Annual Residents Writing Competition in 1968.



SCIENTIFIC PAPERS



Figure 1(a): Admission roentgenogram showing extensive involvement of left lower lobe. Arrows point to cavities in superior segment.



Figure 1(b): Roentgenogram of same patient taken ten days following left lower lobectomy, showing extensive exudative tuberculosis of remaining left upper lobe.



Figure 2: Admission roentgenogram. 23-year-old white male. Large tuberculosis cavity on right, simulating lung abscess.



Figure 3: Admission roentgenogram. 73-year-old white male. Bilateral lower lung field infiltrations. Sputum positive for M. tuberculosis.

hospital benefit. The total length of hospitalization was 18 months.

The marked morbidity of this patient was, for the most part, due to iatrogenic factors. Had the correct diagnosis been made early and proper chemotherapy instituted, the surgical procedure might not have been necessary.

Materials

The material for this report was obtained from the Tuberculosis Section of the Veterans Administration Hospital, Allen Park, Michigan covering a 20-year period from January 1947 to December 1967. The total number of patients admitted with pulmonary tuberculosis was 3,663. Thirty-three, or 1 per cent of whom had lower lung field tuberculosis on the basis of the following criteria:

(a) Bacteriologically proven tuberculosis
(b) Disease confined to one or both lower lung fields

As defined previously,[10,12,15] the lower lung fields occupy the area on a postero-anterior chest roentgenogram below an imaginary horizontal line drawn across the hila, including the perihilar regions.[12] In a postero-anterior view, this will include the middle lobe and lingula in addition to the lower lobes. In this report, we use the term lower lung field tuberculosis to include the middle lobe, lingula and lower lobes, since the disease in these areas behaves in a similar manner.[14] **Figures 2** and 3 illustrate roentgenograms of two typical patients.

Results

Thirty-four patients were males and 2 females; 30 were white and 6 Negro. These figures approximate the ratio of white to Negro patient population in the tuberculosis section of this hospital during this period. The ages varied from 21 years to 73 years, with peak incidence in the third and fourth decades of life (**Table 1**).

Symptomatology

Toxic manifestations such as fever, chills, anorexia, night sweats and weight loss were generally present (**Table 2**). Cough was present in 27 patients and in 24 patients it was productive. Eleven patients had hemoptysis. Pleuritic chest pain was present in 14 patients, but dyspnea was uncommon. Others had miscellaneous symptoms such as vague gastrointestinal disturbances, palpitations and dizzy spells.

Relationship to Other Diseases

Twenty patients had co-existing diseases; diabetes mellitus was present in 7 patients. Four patients were chronic alcoholics and 2 were on long-term steroid therapy for other medical conditions. One of the two women had had an incomplete spontaneous abortion; the tuberculosis was discovered while she was in the hospital for cervical dilatation and curettage. Other diseases included single cases of peptic ulcer, pulmonary emphysema, hypothyroidism, diverticulitis, and idiopathic thromboeytopenic purpura.

Pulmonary Distribution

The disease showed a predilection for the right lung which was involved in 22 cases. The left lung was affected alone in 5 cases, and the disease was bilateral in nine. In 1 patient, the disease was confined to the right middle lobe and the correct diagnosis was established only after histologic examination of the resected lobe; the pre-operative diagnosis was "right middle lobe syndrome." Cavitation occurred in 24 patients and in 5 cases these were multiple cavities.

Twenty-nine patients had evidence of endobronchial disease as determined by clinical, roentgenographic and bronchoscopic findings. Nine of these patients were bronchoscoped and six showed endobronchitis. The criteria used for the clinical roentgenographic evidence of endobronchial disease have been reported previously.[6,10,12]

Bacteriology

M. tuberculosis was recovered from the sputum of 31 patients, from gastric washings in 2, and

TABLE 1

AGE INCIDENCE IN 36 CASES OF LOWER LUNG FIELD TUBERCULOSIS

Age Group in Years	No. of Patients
20 - 30	16
31 - 40	8
41 - 50	6
51 - 60	3
61 - 70	2
71 - 80	1

TABLE 2

SYMPTOMATOLOGY OF LOWER LUNG FIELD TUBERCULOSIS

Signs and Symptoms	No. of Patients
Cough	27
Productive	24
Non-Productive	3
Fever	15
Chest pain	14
Weight loss	14
Hemoptysis	11
Night sweats	11
Anorexia	10
Chills	5
Dyspnea	3
Miscellaneous	14

from bronchial washings in 1. In 2 patients cultures of sputum and gastric and bronchial washings were negative, the diagnosis being made only after thoracotomy. (Table 3)

Treatment

Pneumoperitoneum and phrenic nerve crush in combination with streptomycin and PAS were used in two patients treated in the earlier years. Since the advent of isoniazid in 1952, medical therapy alone was effective in controlling the disease in 22 patients. In 12 patients surgical resection was done in addition to chemotherapy because of persistence of cavities. (Table 4)

Prognosis

One year after discharge from the hospital 25 patients were well and working. Three patients had recently been discharged and had not yet been released for work; another was unemployed because of mental incompetency. Five patients were lost to follow-up. Two deaths occurred during the period of hospitalization. One was a sudden death in a 32-year-old, chronic alcoholic. Postmortem findings showed muco-purulent bronchitis, sclerosing pleuritis and emphysema in addition to tuberculosis. The other was an operative mortality due to massive uncontrolled hemorrhage during thoracotomy.

Twenty of 24 patients who were followed for a year returned for a three-year follow-up. All were in good health and working full time.

Sixteen patients were followed for more than five years. Eleven were well and working. Three patients were incapacitated; 1 had bronchiectasis and respiratory insufficiency developing 9 years after discharge; another had anemia of undetermined etiology and the third patient had a cerebrovascular accident with residual right hemiplegia. Two patients had died of causes unrelated to tuberculosis and without recurrence of the disease.

Discussion

The incidence of lower lung field tuberculosis in this study (1 per cent) is relatively low in comparison with some other reports[6,8,9,10,14] which are in the range of 2 to 3 per cent. This may be due to the predominance of men in the series, as this form of tuberculosis is usually more common in women.[7,10,12,13,15]

Most of our observations confirm the work of other authors.[6,10,12,13] Lower lung field tuberculosis is essentially a disease of young people; the right lung is more commonly involved and cavitary lesions are prevalent. Diabetes mellitus is also common.[3,12,13]

TABLE 3

SOURCE OF POSITIVE BACTERIOLOGIC CULTURE

Source	No. of Patients
Sputum	31
Gastric Washing	2
Bronchial Washing	1
Thoracotomy	2

TABLE 4

THERAPY EMPLOYED IN 36 CASES WITH LOWER LUNG FIELD TUBERCULOSIS

Therapy	No. of Patients
Chemotherapy alone	22
Pneumoperitoneum Phrenic nerve crush Chemotherapy	1
Pneumoperitoneum Phrenic nerve crush Chemotherapy Resection	1
Chemotherapy Resection	12

GENERIC AND TRADE NAMES OF DRUGS

Isoniazid — Armazide
Catinazin
Dimacrin
Ditubin
Isolyn

Para-Amino-Salicylic Acid — Pamisyl
Para-pas
Parasal
Rezi-pas
Propasa

It is interesting to note that 1 of the 2 women in this study had been pregnant and had had an incomplete abortion; some authors have mentioned that pregnancy is a predisposing factor. Four of Reisner's[13] female patients with lower lung field tuberculosis were pregnant and Chambers[6] reported that 7 of 33 female patients in his series were pregnant.

There is nothing pathognomonic in the symptomatology of this form of tuberculosis. Toxic manifestations are quite as common as in other diseases.

Ostrum and Serber[15] have described two types of roentgen lesions seen in lower lung field tuberculosis. One type is characterized by transverse streaks of infiltration at, or just above or below the perihilar area. The second type, which is more commonly seen, takes the form of consolidations of varying size, often with cavity formation. This early cavity formation is quite striking and has been reported in 72.9 per cent[14] to 78 per cent[10] of cases; our study shows an incidence of 63 per cent.

The diagnosis of lower lung field tuberculosis is not difficult and can be confirmed bacteriologically

in a high percentage of patients, if a careful search is made for the organism. This is evidenced by 86 per cent of the patients in this study whose sputum was positive on culture for M. tuberculosis. In cases in which the sputum was negative, the organism was recovered from gastric or bronchial washings in all but two, and in these, the organism was found in the surgical specimen. However, Hamilton and Fredd[8] have reported that the sputum is often negative in these cases; the reason for this discrepancy is not apparent. Hypertonic saline aerosol stimulation of sputum is routinely employed in this hospital and multiple specimens are collected before instituting drug treatment.

The prevalence of endobronchial disease observed in our series as well as by others[5,9,10,12] strongly supports the concept that the disease results from the perforation of a lymph node into the bronchus, followed by spillage of the infected material into the pulmonary parenchyma.[12]

A marked change in the outlook of this type of tuberculosis has occurred in the last two decades. Earlier writers, in the 1920's, described basal lesions as treacherous, virulent, and often fatal. Prognosis was considered grave until 1935, when it was first pointed out that the course in these patients was not particularly different from patients having similar caseo-cavitating lesions in the apices.[13]

However, lower lung field tuberculosis still remained a therapeutic problem. Several types of treatment were in vogue, such as bed rest, pneumothorax, pneumoperitoneum, phrenic nerve crush, cavernostomy, resection and occasionally thoracoplasty. Chemotherapy was limited and the overall results were disappointing. With the introduction of streptomycin in 1944 and isoniazid in 1952, morbidity and mortality rates decreased.

In our series, more than half of the patients recovered with chemotherapy alone. However, early and prompt recognition of the disease still plays an equally important role in the prognosis, so it behooves physicians to become aware of the existence of this form and localization of tuberculosis.

Summary

Thirty-six of 3,663 patients with pulmonary tuberculosis admitted to the Veterans Administration Hospital, Allen Park, Michigan over a period of 20 years had lower lung field tuberculosis. The peak incidence was in the third and fourth decades of life. Bacteriologic confirmation of diagnosis was obtained in 94 per cent of patients, and in 86 per cent this was from examination of sputum alone. Toxic manifestations and endobronchial disease were common. The right lung was more frequently involved than the left, and there was high tendency towards cavity formation. More than half of the group responded to chemotherapy alone. The importance of early diagnosis and prompt institution of treatment is emphasized.

Acknowledgments

The writers thank Mrs. Gertrude Dingeman and Mrs. Ursula Adams, at the Veterans Administration Hospital, Allen Park, Michigan for their assistance in collecting the clinical charts and especially for their tireless efforts in tracing patients reported herein. The authors also wish to thank Dr. Grosvenor W. Bissell, Chief of Medicine, Veterans Administration Hospital, Allen Park, Michigan for editing the manuscript.

References

1. Kidd, P.: Basic Tuberculosis Phthisis, *Lancet* 2:615 and 2:665, 1886.
2. Fowler, J. K.: *The Localization of the Lesions of Phthisis: In Relation to Diagnosis and Prognosis,* J. & A. Churchill, Ltd., London, 1888, p. 7.
3. Andosco, J. B. and Foley, J. A.: Basal Tuberculosis, *J. Thorac. Surg.* 12:259, 1943.
4. Ross, E. L.: Tuberculosis in Nurses: Study of the Disease in 60 Nurses Admitted to the Manitoba Sanatorium, Canada, *Med. Assoc. J.* 22:347, 1930.
5. Weidman, W. H. and Campbell, H. B.: Lower Lobe Tuberculosis, *Amer. Rev. Resp. Dis.* 36:525, 1937.
6. Chambers, J. S., Jr.: Tuberculosis Cavities of the Lower Lobe, Results of Treatment in 103 Patients, *Amer. Rev. Resp. Dis.* 63:625, 1951.
7. Fries, J. W.: Lower Lobe Tuberculosis, *J. Mich. Med. Soc.* 54:1310, 1955.
8. Hamilton, C. E. and Fredd, H.: Lower Lobe Tuberculosis: A Review, *JAMA* 105:427, 1935.
9. Ossen, E. Z.: Tuberculosis of Lower Lobe, *New Eng. J. Med.* 230:693, 1944.
10. Parmar, M. S.: Lower Lung Field Tuberculosis, *Amer. Rev. Resp. Dis.* 96:310, 1967.
11. Romendick, S. S., Friedman, B. and Schwartz, H.: Lower Lung Field Tuberculosis, *Dis. Chest* 10:481, 1944.
12. Segarra, F., Sherman, D.S. and Rodriquez-Aguero, J.: Lower Lung Field Tuberculosis, *Amer. Rev. Resp. Dis.* 87:37, 1963.
13. Reisner, D.: Pulmonary Tuberculosis of Lower Lobe, *Arch. Intern. Med.* 56:258, 1935.
14. Vivas, J. R. and Laubach, C. A.: Observations on Lower Lobe Disease in Pulmonary Tuberculosis, *Amer. Rev. Resp. Dis.* 60:15, 1949.
15. Ostrum, H. W. and Serber, W.: Early Roentgen Recognition of Lower Lobe Tuberculosis, *Radiology* 53:42, 1949.

Editorial Note

It is important to note that 20 of these cases had coexisting disease of the types predisposing to tuberculosis. When such diseases exist and lower lung field disease is present, one should consider tuberculosis. It is evident from the positivity of sputum studies, 86%, that if one suspects tuberculosis the diagnosis is not difficult.

— John W. Moses, M.D.
Scientific Editor

Use of Cholesterol Kits

(Note: Attention is called to this article in the New England Journal of Medicine, Vol. 279, No. 18 by Kenneth R. Wilcox, Jr., M.D., Associate Director for Laboratory Services and Chief, Bureau of Laboratories, State Department of Public Health.

Doctor Wilcox points out, "There are many kits for doing clinical chemistries in the physician's office becoming available. Although some of them may be adequate for their purpose, many of them give a false sense of security since the quality of results obtained by these kits is poor. With the clinical chemistry laboratories that we have available in this State, physicians should think twice before attempting to perform these tests with unskilled help in their offices. Although this may superficially appear to be a convenience, in the long run the inaccuracies of these tests may work to the patients' disadvantage.

"This editorial refers to a paper in the same issue that is a careful study of the kits available on the market at the time.")

Determination of the serum cholesterol concentration has become an important part of medical evaluation, especially before the sixth decade of life. Although a normal or low serum cholesterol does not rule it out, a high cholesterol is strong evidence for the presence of inherited or acquired disease of lipoprotein metabolism[1] and of an increased risk of arteriosclerosis. The cholesterol determination is also useful as a diagnostic test and an index of the efficacy of treatment in acquired conditions such as hypothyroidism and liver disease, and in the nephrotic syndrome.

In patients with inherited diseases of lipoprotein metabolism, treatment is usually directed primarily at lowering the concentration of serum cholesterol. In such cases a cholesterol determination is often an emotionally weighted test. A low result signifies to the patient, far more than to the doctor, success in holding off a threat to health and life, and a high value suggests failure. It is for many reasons, then, that accuracy and reproducibility are of great importance in a method for determining the serum cholesterol concentration.

Elsewhere in this issue, Barnett, Cash and Junghans report on the results obtained with the use of 12 different commercial "kits" for cholesterol analysis. These sets are designed for use in laboratories or doctors' offices whose work load does not justify training a technician to perform the tedious but reliable methods of Sperry and Webb[2] or Abell and Kendall.[3] In the hands of the authors, who are experienced clinical chemists, 10 of 12 "kits" sold for the purpose did not perform satisfactorily in measuring serum cholesterol so far as either accuracy or reproducibility was concerned. One can only wonder what the results would be with even the two "successful" kits when they are used only occasionally in a doctor's office or small hospital, perhaps by a person whose training has not been in chemistry.

But cholesterol values are not enough. Accurate assessment of serum lipids must include a triglyceride estimation and preferably a lipoprotein electrophoresis as well. Without these additional tests, significant — even severe — hyperlipemia may go undiagnosed, because it can occur in the presence of a normal cholesteral concentration. When glyceride anaylsis is not possible, simple inspection of the serum from blood drawn 12 to 16 hours after eating is almost as good. Clear serum means normal or only slightly elevated glycerides. Turbidity is diagnostic of hyperlipemia.

One may question the advisability of using cholesterol "kits" at all. The cholesterol concentration alone is not sufficient for complete diagnosis of hyperlipemia. Furthermore, the diseases involved do not generally require immediate diagnosis. Serum can be mailed by air from anywhere in the country to a large hospital or commercial laboratory, and the results returned within a week. The physician and the patient can then be reasonably certain that the value obtained is correct.

Because of the time sensitivity of the color reactions involved and the large number of potential chromogens in plasma that can interfere in them, cholesterol analysis is difficult to perform. It is best done in relatively large numbers by automated technics[4] and with constant quality control. An alternative to the use of "kits" would be for physicians in practice to petition their community hospitals to make automated cholesterol analysis available to them at reasonable cost.

References

1. Fredrickson, D. S., Levy, R. I., and Lees, R. S. Fat transport in lipoproteins: integrated approach to mechanisms and disorders. *New Eng. J. Med. 276*: 32-44, 94-103, 148-156, 215-225 and 273-281, 1967.
2. Sperry, W. M., and Webb, M. Revision of Schoenheimer-Sperry method for cholesterol determination. *J. Biol. Chem. 187*:97-106, 1950.
3. Abell, L. L., Levy, B. B., Brodie, B. B., and Kendall, F. E. Simplified method for estimation of total cholesterol in serum and demonstration of its specificity. *J. Biol. Chem. 195*:357-366, 1952.
4. Block, W. D., Jarett, K. J., Jr., and Levine, J. B. Improved automated determination of serum total cholesterol with single color reagent. *Clin. Chem. 12*:681-689, 1966.

Mammography And Xeroradiography

By John N. Wolfe, M.D.
Detroit

Over the past 30 years, both abroad and in the United States, mammography has had some degree of popularity. Gros and Willemin of France have been enthusiasts. In Uruguay, Leborgne described the importance of calcifications in breast cancer, the significance of which had not been formerly recognized. In this country among the well-known researchers are Ingleby, Gershon-Cohen, and Egan.

Gershon-Cohen has long been an advocate of mammography, having published his first paper on it in 1938. He has contributed much in promoting the procedure's acceptance by the medical profession.

Robert Egan is familiar to most people for his work at the M. D. Anderson Hospital in Houston. In 1,000 examinations by film mammography he achieved an accuracy rate in breast cancer detection of an outstanding 98%, a record not duplicated since. The interest in mammography has increased considerably since this publication in 1960. However, many are still not cognizant of the potential, indications, and limitations of the procedure.

There has been in the past too much emphasis on accuracy. This was probably due to the remarkable findings of Egan and his declaration of 98%. This was interpreted by many to mean that the radiologist's opinion will be almost 100% correct, that doctors could rely on his opinion for the decision whether or not to biopsy. If the patient's physician feels there may be cancer present but decides not to biopsy because of negative radiological findings, he is unwisely laying too much emphasis on the radiologist's report.

The physical examiner should view the radiographic study as a complement to his own. For example, when he suspects the presence of cancer, the radiologist can serve to evaluate the remainder of that breast and possible involvement in the opposite one.

The most significant contribution by mammography, however, is not the confirmation of cancer in the already diagnosed patients but rather the discovery of a carcinoma which is not apparent from the physician's or patient's physical examination.

In this examiner's experience 10% of all cancers seen on film have been either incorrectly judged on physical examination to not require a biopsy or have gone completely unobserved. For example, in women with cystic disease the radiologist often sees small 5-15 mm. cancers which are obscured on physical examination by the presence of numerous palpable cystic masses. Most often, however, the cancer is simply so small as to escape detection by palpation. At the same time, I miss about 8% of the cancers which have been detected in the physical examination.

Certain situations are conducive to a right or wrong diagnosis by the radiologist. The mammograms of a large-breasted multiparous woman are most easily and accurately interpreted, whereas the opposite is true of the small-breasted woman with adenosis. It is unfortunate that the radiologist should have difficulty with accurate diagnosis of the dysplastic breast of young women who also present a problem on physical examination.

In the discussion, one obvious question is — who should have mammography?

I believe all women with physically-apparent indications of breast disease should be examined roentgenographically. For those in whom cancer is obvious, the procedure can help to evaluate the opposite breast.

For women with a questionable physical diagnosis, it can supply further information for the decision whether or not to biopsy. Some women with non-localizing breast complaints as sanguinous nipple discharge, retraction of the nipple, enlargement of one breast or mastodynia have been identified as having carcinoma by mammography.

Often metastatic cancer in other areas of the body can be traced to the breast for its primary source. When a woman is found to have a metastatic lesion of unknown origin in the spine, chest or axilla, a mammogram should be one of the first search procedures performed. Many women are given every other possible examination first when a simple and quickly effected mammogram could often reveal the source.

In addition to the symptomatic women, there are certain groups for which the study should be routine. First and foremost are those in whom one cancer has already been discovered. The remaining breast should be roentgenographed at yearly intervals at least and more often if the physical examination reveals any slight change. Women with mammary dysplasia should be roentgeno-

The author is Chairman, Department of Radiology, Hutzel Hospital, Detroit; and Assistant Clinical Professor, Department of Radiology, Wayne State University. His research work is supported by grants from the United States Public Health Service — Cancer Control Program, Michigan Cancer Foundation, and Hutzel Hospital Research and Education Fund.

graphed periodically as cancer seems to be more prevalent in women with benign disease although this is not conclusive.

Certain other groups of women are also more susceptible to the disease; for example, post-menopausal women having had less than two-three pregnancies, and women with a strong family history of the disease.

Routine examination or screening of all women has strong appeal to many, but it is a very tedious program. The likelihood of finding a cancer is two-three per thousand women over the age of 40 examined. The drawback to the program is the great amount of work required on the part of the radiologist interpreting the mammograms. It would be very difficult to maintain enough attention to find the two-three cases per 1,000 that should be there, and very little of the time involved could be called productive. One would have to say that routine screening is not feasible at this time.

We have used film mammography at Hutzel Hospital for seven years and for the past two we have been doing work in xeroradiography of the breast. This technique is presently little known and little used, but it is nevertheless developing into a significant means of breast cancer detection. It differs from regular mammography in that a selenium-coated aluminum plate records the image rather than the x-ray film. The finished opaque positive xeroradiograph is better for ease of viewing and accuracy of interpretation than the negative translucent x-ray.

In xeroradiography, an electrostatic charge is placed on a photoconductive surface, in our use a selenium-coated aluminum plate. The plate is placed under the part to be examined in a manner as one would use x-ray film. The charge is then dissipated in amounts proportional to the density through which the x-rays pass. The residual charge on the plate represents the breast structure. To transfer this remaining charge pattern into a visible image the plate is sprayed (or dusted) with a negatively-charged blue, thermoplastic powder which adheres to the plate in amounts proportional to the residual positive charge.

The usable and permanent image for interpretation is then obtained by pressing a sheet of plastic-coated paper against the plate, and the powder adheres to it.

Mammograms produced by xeroradiography have distinct advantages over those produced with Eastman Kodak "M" Type Film. There is noted a high local contrast bordering differences in densities which facilitates identification of structures. Because of particle size used in the development of the xeroradiographic image, small points of differences in electrostatic charge on the plate such as those recording the images of calcifications appear to be exaggerated on the final image and are thus more readily identified.

More small calcifications are visible on the xeroradiographic image than can be seen on the film mammograms. There is local accentuation of differences in density such as those produced by arteries and veins, trabecular pattern, and importantly the spiculations around breast cancers. This results in more definite evidence as to whether a particular abnormality within the breast is benign or more important, whether it is malignant.

Contrasting xeroradiography and film mammography reveals considerably less radiation required to produce the image of the former than that utilizing the technique advocated by Egan or Gershon-Cohen. And this is of some importance both as to the amount of exposure to the patient and the x-ray tube life, although the former is perfectly safe with the higher mAs required for film. It is true, however, any procedure which will reduce significantly the amount of irradiation required for image production is more attractive.

Conclusion

	kVp	mAs	Distance
Xerography	26-34	600	32″
Eastman Kodak "M" Film	30-34	1500	32″

Xeroradiography of the breast is superior to conventional film mammography by requiring less radiation to produce, providing an image with good visualization of all breast structures, permitting a more efficient and economical operation and being easier to interpret in that there is accentuation of significant structures. Masses, veins, calcifications and sharp lines are all shown with high local contrast. The process is hampered by poor equipment and plate quality. A new semi-automated machine with excellent plates is needed as a starting point.

Much work needs to be done on toners, paper for transfer, optimum plate voltages, development techniques and many other facets of the process. Thus, many of the limitations of the process can be corrected by the manufacturer, and our results can be even more encouraging.

References

1. Egan, R. L.: Mammography. Springfield: Charles C. Thomas, Publisher, 1964.
2. Gros, Charles M. and Sigrist, R.: "Radiography of the Breast." Gynecologic Radiography. New York: Paul B. Hoefer, Inc., 1959.
3. Ingleby, H. and Gershon-Cohen, J.: Comparative Anatomy, Pathology and Roentgenology of the Breast. Philadelphia: University of Pennsylvania Press, 1960.
4. Willemin, A.: "La Mammographie." Caracteres des Images Malignes. Press Med. 75:2457-2458, November 18, 1967.
5. Wolfe, J. N.: Mammography. Springfield: Charles C. Thomas, Publisher, 1967.
6. Wolfe, J. N.: "Xerography of the Breast." Radiology 91:231-240, August 1968.

Early Management Of Facial Nerve Trauma

By Roger Boles, M.D.
Ann Arbor

Few injuries are more disfiguring than those of the facial nerve which result in facial paralysis. In addition to the cosmetic problem of a sagging, expressionless face, functional problems such as drooling of saliva from the corner of the mouth and difficulty in speech and mastication may occur because of incompetency of the oral sphincter. Inability to close the affected eye may result in corneal abrasions, drying and ulceration.

A number of ingenious operations have been designed to reduce the deformity of facial paralysis. Among them are the substitution operations such as fascial sling support of the sagging parts of the face, and the cross-over anastamoses between the proximal intact XI or XII cranial nerves and the distal cut end of the facial nerves. Resection of selected groups of facial muscles of the opposite intact side of the face has also been advocated in some cases in an attempt to improve facial symmetry.

As an increasing experience with facial nerve injuries is accumulated, especially with an increasing frequency of high-speed auto accidents and war injuries which result in severe facial lacerations and skull fractures, it has become quite apparent that immediate or early surgical repair of the facial nerve is technically much easier and functionally much superior to delayed repair of the nerve or to substitution techniques.

Several recent technical advances have made early repair of the nerve more feasible and successful:

1. The cut or crushed segments of the nerve are much easier to identify and repair accurately in a fresh wound than they are in an old, scarred wound.

2. Early repair, within three days of the nerve injury, makes possible the use of an electrical nerve stimulator for helping to find the cut ends of the fine peripheral branches. (**Fig. 1**) These fine branches are often very difficult to locate by direct inspection of the wound, especially if there has been significant disruption of the tissues. The fine probe of the nerve stimulator can be advanced, at low amperage, along the anterior wound edge until an isolated twitch of the face is produced. The surgeon then knows that there is a branch of the nerve within a few millimeters of the probe and careful inspection and dissection in this area using an operating microscope will usually readily reveal this branch.

If the patient's general condition is stable enough for careful primary wound repair, repair of the facial nerve segments can also be done at this time without unduly prolonging the operating time. If the patient's general condition is too unstable for careful immediate primary wound repair, the cut nerve endings can at least be identified and tagged with fine, visible suture material. This will facilitate identification of these fine branches at the time of later secondary repair. Unfortunately, a severed peripheral motor nerve, such as the facial nerve, loses its electrical excitibility within 3 days of the injury and thereafter will never react significantly again to direct electrical stimulation. This very helpful aid in identifying fine peripheral branches of the facial nerve is lost, therefore, if not utilized within the first three days of the injury. Without it, some of the fine peripheral branches may never be identifiable with certainty again.

3. The earlier and more accurate the repair of the disrupted facial nerve, the earlier and more complete will be the axonal regeneration to the paralyzed facial muscles. The sooner these muscles are reinnervated and stimulated to contract regu-



Figure 1. Portable facial nerve stimulator

Doctor Boles is associated with the Department of Otorhinolaryngology at the University of Michigan, Ann Arbor.



Figure 2. Operating microscope

larly, the less they will atrophy and undergo fibrosis. Nerve regeneration takes place at the approximate rate of one millimeter per day. If the injury is quite proximal along the nerve, it may take as long as six to seven months for the axons to reach the peripheral muscle groups. If added to this prolonged period of regeneration is a two, three or four month delay in the surgical repair of the nerve, undue facial muscle wasting must be expected.

4. Certainly such modern surgical adjuncts, as improved anesthetic agents and techniques, more accurate blood and fluid replacement, and antibiotics, have all supported earlier definitive surgical management of the acutely injured patient, including patients with extensive craniofacial injuries.

5. Surgical repair of peripheral nerves has been greatly enhanced in the past decade by the introduction of the operating microscope. **(Fig. 2)** The great advantages of bright illumination and high magnification of the surgical field, which have made the microscope so indispensable in middle ear surgery, have made it equally valuable in repairing the facial nerve. If an operating microscope is not available, surgical loops providing 4x and 6x magnification will be very helpful.

6. Recently developed, fine, atraumatic and nonreactive synthetic suture materials of 7-0 and 8-0 gauges have further improved our ability to achieve extremely accurate approximation of the cut ends of nerves. Accuracy in these anastamoses minimizes neuroma formation and facilitates axonal migration through the anastamotic sites.

Cases:

Case 1. M.D., 16-year-old white female was brought to the emergency room minutes after being involved in an auto accident in which her head penetrated the windshield from the front passenger seat. Multiple deep facial lacerations were sustained apparently as a result of the initial penetration of the windshield as well as from reentry of her head through the ragged glass opening as she fell back into the car. **(Fig. 3)** The patient was not wearing a seat belt.

A large amount of blood was lost at the scene of the accident and en route to the hospital, as manifested by a moderately rapid pulse and mild hypotension. Circulating blood volume and normal vital signs were quickly restored by the immediate administration of 2000 cc of Hartmans solution and 50 gms of albumin intravenously in the emergency room and shortly thereafter by whole blood transfusions as soon as blood could be properly typed and cross-matched. In addition to her facial lacerations the patient had multiple facial bone fractures including a fracture of the mandible. She was fully conscious and with no evidence of severe intracranial injury. There were no other torso or extremity injuries. A tracheostomy was performed in the emergency room because of the massiveness of the facial trauma and the extensive bleeding onto the upper airway. Major bleeding was controlled in the emergency room and the patient then moved to the operating room for primary wound repair under general anesthesia.

Before being anesthetized, the patient was asked to move her face and it became obvious that most of the branches of the facial nerve on the left side of the face had been severed, except possibly the ramus mandibularis. Facial motion was intact on the right side despite the rather deep right facial laceration.

Under general anesthesia through the tracheostomy site, the facial wounds were thoroughly



Figure 3. Case 1, Facial lacerations involving facial nerve and parotid duct



Figure 4. Case 1, Early post injury, left facial paralysis

cleared of broken glass fragments. Using the operating microscope under 16x magnification and the nerve stimulator, the small distal ends of four severed branches of the facial nerve were identified along the anterior margin of the deep left facial laceration. Dissection was carried back into the parotid tissue along the posterior edge of the laceration until all of the corresponding larger proximal branches of the nerve were clearly identified. All of the cut branches were reapproximated under microscopic control using 7-0 Tevdek* suture material. The parotid duct was also found to be completely transected and this was reapproximated with fine suture material over a piece of indwelling number 90 polyethylene tubing which had been inserted through the duct orifice in the mouth and passed back into the wound and then introduced into the proximal cut segment of the duct. This polyethylene tubing was removed through the mouth after ten days and no impairment of salivary flow was ever experienced. The facial and mandibular fractures were reduced and wired and further stabilized by intermaxillary wiring. The facial lacerations were then carefully repaired with 4-0 catgut sutures subcutaneously followed by 6-0 nylon sutures in the cutaneous layer.

Immediately postoperatively the patient, of course, had a complete paralysis of the left side of her face except for the chin and lower corner of the mouth supplied by the intact ramus mandibu-

*Teflon Impregnated Dacron, J. A. Deknatel and Son, Inc.



Figure 5. Case 1, One year post-injury and repair of left facial nerve

laris. (**Figure 4**) Within 4 months of the injury she had recovered good symmetry of the face in repose and some early voluntary motion on the left side. By eight months she had almost complete recovery of left facial movement and by one year there was excellent left facial motion with minimal synkinesis.(**Figure 5**)

Case 2. A 21-year-old white male who was brought to the emergency room shortly after having been involved in an auto accident in which he sustained a nasal fracture and lacerations of his left face and neck. Although at the scene of the accident he had been rendered transiently unconscious, in the emergency room he was alert, well-oriented and with normal vital signs. He had a 14 cm. laceration in the posterior triangle of the left side of the neck which did not injure the underlying XI nerve. He also had a deep laceration of the left anterior cheek extending from the medial canthal area to the upper lip. (**Figure 6**)

On careful observation of the various voluntary movements of the facial muscles it was readily apparent that the mid-third of the left side of the patient's face was paralyzed, including the upper lip and nose. This localized paralysis and the site of the laceration indicated that the underlying buccal branch of the facial nerve had been severed. A comminuted nasal fracture was also detected by physical examination and by X-ray.

The patient was taken directly to the operating room where under general anesthesia the facial wound was cleaned and carefully explored. In the upper part of the wound the lacrimial sac was found to be lacerated and this was repaired with 4-0 catgut sutures. Using the operating microscope and the nerve stimulator, the anterior wound edge was probed until the mid-third of the face twitched. Within a millimeter of the tip of the electrical probe the fine distal cut end of the buccal branch of the facial nerve was identified using the operating microscope. The larger proximal portion was found in its usual proximity to the parotid duct on dissecting back into the sub-



Figure 6. Case 2, Facial laceration involving buccal branch of facial nerve



Figure 7. Case 2, Early post-injury left mid-third facial paralysis



Figure 8. Case 2, Two years post-injury and repair of buccal branch of left facial nerve

stance of the parotid gland in the posterior edge of the wound. The cut ends were then accurately approximated under the microscope with an 8-0 silk suture. The facial and neck wounds were closed in subcutaneous and cutaneous layers after the nasal fracture had been reduced and wired.

Immediately postoperatively the patient continued to manifest his mid-third left facial paralysis. (**Figure 7**) However, within 3 months of the injury good tonus had returned to this part of the face and by 6 months he had good return of function. A two year follow-up revealed good facial function, minimal scarring and no epiphora from the left eye. (**Figure 8**)

Surgical Techniques for Repair Of the Facial Nerve in Soft Tissues:

1. End-to-end anastamosis:

This is the most favorable repair technique. It can be used in rather clean lacerations of the nerve in the soft tissues of the face where there has not been significant loss of substance of the nerve. The perineurium should be carefully, but not too tightly, approximated with two, three or four individual 8-0 or 7-0 non-reactive, atraumatic

sutures, depending upon the size of the injured branch or segment of the nerve.

2. Nerve grafting:

Grafting becomes necessary when facial nerve substance is lost in ragged soft-tissue injuries of the face, and almost always in facial nerve injuries within the temporal bone. Various peripheral cutaneous nerves, such as the great auricular nerve in the neck and the lateral femoral cutaneous nerve in the thigh may be used as donor grafts. These cutaneous sensory nerves are readily accessible surgically and have up to three or four branches which may be used for branch grafting if necessary. Nerve grafting introduces the inescapable disadvantage of multiple anastomotic sites through which axonal regeneration must take place. Nevertheless, the majority of these grafts result in satisfactory appearance and function of the face.

3. Intratemporal Repair:

Injuries of the facial nerve within the temporal bone are more complex because of the difficulty in determining the exact site and degree of injury. In general, the following principles may be applied in such cases:

A. Onset of Paralysis:

1. If a facial paralysis is sudden and immediately complete at the time of the skull fracture, the facial nerve within the temporal bone is undoubtedly disrupted and should probably be surgically explored and repaired as soon as the patient's general condition permits.

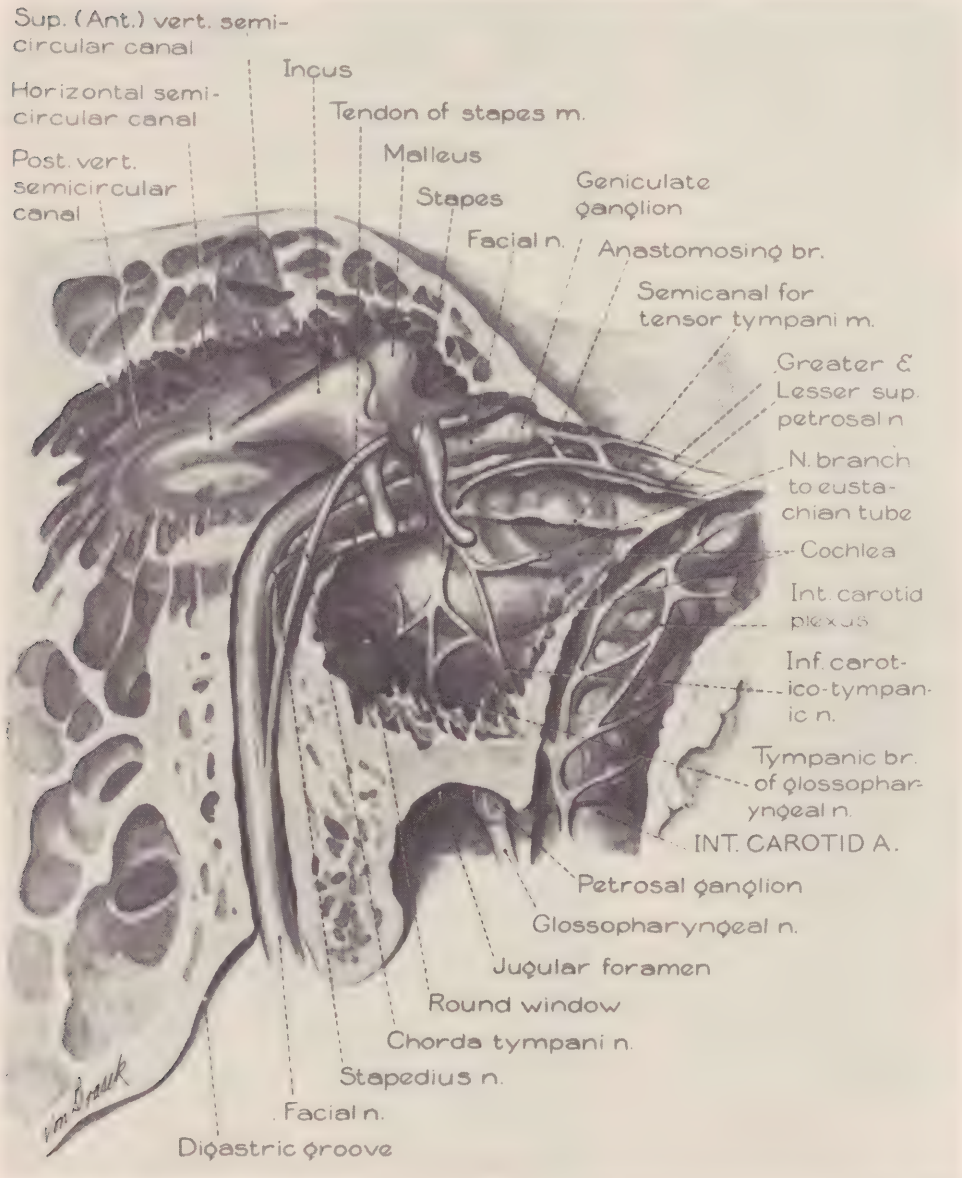


Figure 9. Relations of the facial nerve and geniculate ganglion to the middle ear and mastoid. (From Shambaugh, **Surgery of the Ear)**

2. If a facial paralysis develops gradually, or is delayed until some time after the skull fracture, it is due to physiologic impairment of transmission of impulses along the intact nerve by edema, hematoma, ischemia or possibly by bone fragments which are impinging upon the nerve. The continuity of the nerve is assured, however. This type of paralysis is probably best treated expectantly in most cases. Such a paralysis, if complete, should be followed serially every two or three days with electrical testing to determine the excitability, and thereby the viability, of the nerve. If electrical tests begin to show progressive reaction to degeneration in the nerve, surgical exploration and decompression of the nerve through a mastoidectomy approach should be considered.

B. Site of Injury:

The single most important clinical distinction to be made in localizing the site of an intratemporal injury of the facial nerve is whether the injury is central or distal to the geniculate ganglion. This ganglion lies in the anterior-superior part of the medical wall of the middle ear. (**Figure 9**) Injuries distal to the geniculate ganglion – that is, in the middle ear or mastoid portions of the temporal bone – are surgically approachable through standard mastoid operations. Injuries central to the geniculate ganglion, in the petrous portion of the temporal bone, are much more inaccessible surgically and usually require a middle fossa craniotomy approach for repair. Autonomic secretory fibers innervating the lacrimal gland of the eye are contained in the petrous portion of the facial nerve but exit from the nerve anteriorly at the geniculate ganglion as the Greater Petrosal Nerve. From this point on, the facial nerve turns sharply backward into the middle ear and mastoid, devoid of any more lacrimal fibers. Absence of lacrimation on the side of the facial nerve injury, therefore, is strong presumptive evidence of injury to the nerve central to the geniculate ganglion. Normal lacrimation, on the other hand, indicates that the nerve has been injured distal to the geniculate ganglion in the more readily accessible middle ear or mastoid regions. Lacrimal function is easily and reliably tested with the Schirmer test using strips of filter paper in each conjuntival sac and noting the differences in wetting of the paper between the normal and injured sides.

Summary

1. Early primary repair of facial nerve injuries by anastamosis or grafting techniques give better cosmetic and functional results than other delayed or substitution procedures.

2. Injury to the facial nerve should always be considered in deep lacerations of the side of the face. The facial nerve injury should be repaired primarily at the time of initial wound closure if the patient's general condition is satisfactory. If an unstable or deteriorating general condition contraindicates careful primary wound closure and nerve repair, the severed ends of the nerve should at least be identified and tagged with fine visible suture material so that later secondary identification and repair will be possible or facilitated.

3. Identification and repair of the finer branches of the facial nerve have been greatly enhanced by the early use of the nerve stimulator and the operating microscope. The nerve stimulator will be helpful in identifying the fine peripheral cut ends of the nerves only within the first 72 hours after injury. The reaction of degeneration in the peripheral segments thereafter renders these segments no longer electrically excitable.

4. Facial paralysis resulting from skull fractures involving the temporal bone must be carefully assessed regarding the time of onset and the location of the injury within the temporal bone. Immediate paralysis at the time of the injury suggests physical disruption of the nerve within the temporal bone, and early surgical repair of the nerve should be considered through either a mastoid or middle fossa approach. Delayed onset of facial paralysis after the injury is usually due to edema or transient ischemia and will usually recover spontaneously without surgical intervention. Such a paralysis should be followed closely with serial electrical testing. If electrical testing begins to show reaction of degeneration, surgical exploration of the nerve should be considered.

5. The presence or absence of lacrimation on the involved side is important in determining the site of an injury of the facial nerve within the temporal bone.

References

1. Campbell, E. D. R.; Hickey, R. P.; Nixon, K. H.; and Richardson, A. T.: Value of Nerve Excitability Measurements in Prognosis of Facial Palsy. British Medical Journal, Vol. 2:7, 1962.
2. House, W.: Surgery of the Petrous Portion of the VII Nerve. Annals Otol., Rhinol. and Laryngol. Vol. 72: 802, 1963.
3. Kettel, K.: Repair of Facial Nerve in Traumatic Facial Palsies. AMA Arch. Otolaryn. 67:65, 1958.
4. Lathrop, F. D.: Surgical Repair of the Facial Nerve: Surgical Clinics of North America, Vol. 36, pp 583-88, June, 1956.
5. Maxwell, J. H.: Repair of Facial Nerve after Facial Lacerations. Transactions Amer. Acad. Ophthal. and Otolaryn. Sept.-Oct. 1954.
6. Schneider, R. C. and Boles, R.: Combined Neuro-Otologic and Neurosurgical Problems in Head Trauma: Laryngoscope; Vol. 78:6, June, 1968.
7. Shambaugh, G. E., Jr.: Surgery of the Ear. 2nd Edition W. B. Saunders Co., Phila., Pa. and London, England, 1967.
8. Work, W. P.; and McCabe, B. F.: Disorders of the Salivary Glands Chapt. 9: Otolaryngology: Coates, G. M. and Schenck, H. P. W. F. Prior Co., Inc., Hagerstown, Md., 1960.

Abstract:

Current medical treatment for hypercalcemia in malignancy is reviewed. A case report is presented which emphasizes the usefulness of hypophosphate therapy.

Treatment of Hypercalcemia

By Joseph J. Weiss, M.D.
Jose Yanez, M.D.
Both of Eloise

Severe hypercalcemia often accompanies malignant diseases with bone metastases. This complication requires aggressive management. The following report presents a useful approach to the medical treatment of hypercalcemia and brings to the reader's attention recent advances in therapy.

Case Report:

WCGH #381325 (H.K.). This 61-year-old white woman was admitted because of weight loss, anorexia, nausea, and vomiting of approximately six weeks duration. Ten years prior to admission she noted painless enlargement of her thyroid gland. She was found to have a fetal adenoma and total thyroidectomy was performed. She was then placed on desiccated thyroid. She remained well for three years, when she noted the appearance of multiple masses in the neck. Re-exploration revealed a follicular adenoma; limited neck dissection was done. Thereafter she received radio-iodine and cobalt therapy. Six months prior to admission she experienced extreme pain radiating down her right leg when she walked, and noted an enlarging mass in her right buttock and hip. Her only medication at that time was desiccated thyroid, 300 mgm daily.

Physical examination on admission revealed a cachectic white woman with multiple healed surgical scars on her neck. No lymph nodes in the cervical, supraclavicular, or axillary areas were palpable. A firm, diffuse, non-tender mass was present in the right buttock and right hip; otherwise physical examination was normal. X-rays showed osteolytic involvement of the right ischium and right superior pubic ramus.

Laboratory studies revealed a hemoglobin of 11.2 gm%, creatinine of 3.2 mg%, serum calcium of 15 mg%, serum phosphorus of 4.5 mg%, and alkaline phosphatase 56 IU (normal 15-35 units). Whole body radioactive scan after TSH stimulation showed marked increase of radioactivity in the right hip and right buttock corresponding to the area where the masses were previously felt.

Clinical impression was hypercalcemia secondary to bone metastases from thyroid carcinoma.

Hospital course: The patient's desiccated thyroid was discontinued. She was placed on a low calcium diet and encouraged to drink between 3,000-4,000 cc of fluid per day. Serum calcium remained in the range of 14-15 mg%. Sodium phytate (Rencal-Squibb) 9 gm a day in three divided doses, was added to her regimen, but was discontinued after three days because of increased nausea and vomiting. Because of her continued deterioration she was started on prednisone 40 mgm daily for ten days. This therapy had no effect on her serum calcium or her clinical course. Then 100 mM of a balanced hypophosphate solution was given intravenously over an eight hour period. Immediately before this therapy, the patient's serum calcium was 15.8 mg%; serum phosphorus was 4.9 mg% and serum creatinine 2.3 mg%. Immediately after the infusion the serum calcium dropped to 7.5 mg%; phosphorus was 4.9 mg% and creatinine 2.2 mg%. The patient had no further nausea or vomiting, and a markedly improved appetite. She was then placed on oral sodium-potassium phosphate 5 gm tid. Over the following five days her serum phosphorus dropped to 3.3 mg% and her serum calcium stabilized at 8-10 mg%. The patient was then treated with radioactive iodine, 300 mCi in an attempt to control hip metastases. The patient's serum calcium remained normal thereafter.

Discussion

This case illustrates stepwise management of hypercalcemia. Initially, therapy should consist of a low calcium diet (150 mg or less) and forced

Both authors are associated with the Department of Medicine, Division of Endocrinology, Wayne County General Hospital, Eloise, Michigan 48132.

fluids to 3,000 cc a day. This diet includes no milk or cheese, eggs or nuts. It may be necessary to use distilled water for preparing the patient's coffee or tea; saltines may be used instead of bread which usually contains milk solids. The diet is supplemented with liberal amounts of fruits, flavored gelatin, rice and sugar to provide an adequate caloric intake.

Initial therapy may also include sodium phytate (inosital hexaphosphate acid, Rencal-Squibb) three grams, three times a day. This compound blocks absorption of calcium by binding it into an insoluble calcium complex. It is necessary to give the powdered phytate in cold water because of the compound's high heat of hydration. It is also important not to give the phytate with aluminum hydroxide (i.e., gelusil, aludrox, mylanta, polymagna, etc.) since phytate will bind aluminum in preference to calcium. Side effects of phytate include decreased B_{12} absorption, and, as this patient demonstrated, gastrointestinal upset.

If these measures fail to decrease serum calcium levels, it may be necessary to use other methods such as steroids or phosphate solutions.

The use of steroids for treatment of hypercalcemia dates to 1954 when Dent observed that balance studies indicated cortisone caused decreased absorption of calcium from the gut.[1] Use of steroids in a variety of malignancies revealed that cortisone or its equivalent, 150 mgm per day, in divided doses, would cause a reduction in serum calcium levels in 5-10 days. The mode of action of the steroids is uncertain. Evidence shows that these compounds act on the balance between plasma calcium and its concentration in the GI tract, kidney tubules, and bone matrix. Others believe that steroids have a direct anti-tumor effect or act to reduce inflammation surrounding tumor metastases.

Because steroids are ineffective in a significant number of cases, other agents have been investigated in treatment of hypercalcemia. The agent most thoroughly studied at present is inorganic phosphate.

In 1930 Bulger reported the use of inorganic phosphate in decreasing serum calcium levels in hyperparathyroidism. Subsequent use of the compound was delayed because of fear of possible nephrolithiasis and extraskeletal calcification.[2] However, Goldsmith and Ingbar in 1966 reintroduced use of inorganic phosphate.[3] They reported good therapeutic results with a minimum of side effects in 15 patients.

They used an 0.081 molar solution of sodium hypophosphate and 0.019 molar solution of potassium hypophosphate to make a one liter solution containing 100 mEq of inorganic phosphate, 162 mEq of sodium, and 19 mEq of potassium. The same solution was used in the patient described above. This solution was easily prepared by the hospital pharmacy and sterilized by ordinary autoclaving.

In Goldsmith and Ingbar's series, serum calcium averaged 16 mg% before treatment and 10 mg% after treatment. Blood Urea Nitrogen remained unchanged. Normocalcemia was maintained for 6-15 days after the infusion.

Soon after their report other articles appeared warning that infusion of hypophosphate could lead to hypocalcemia, hypotension, oliguria and death.[2] These reports prompted Goldsmith and others to recommend that infusion of hypophosphate be undertaken over 6-8 hours, with serum calcium determinations after infusion of 50 mEq.[4] More recently Massry and his group, using such precautions, had no adverse effects in 10 patients treated with intravenous phosphate therapy.[5]

The mode of action of hypophosphate appears to be via the formation of calcium hypophosphate precipitate. The precipitate presumably forms in soft tissue such as lung, kidney, liver, and in bone.[5]

The reason for the prolonged effect of the hypophosphate is uncertain. Perhaps the delayed return of increased calcium is related to sluggish parathyroid activity. This sluggishness may be secondary to prolonged suppression of the parathyroid glands by the high serum calcium levels.

In our patient, success of the intravenous phosphate prompted use of the same therapy on an oral basis. A package of 11.5 grams of sodium hypophosphate plus 2.5 grams of potassium phosphate was divided into three doses and given with orange juice; the patient tolerated this therapy well. Massry and his group used an oral phosphate of similar composition with good results.[5]

Other agents used to treat hypercalcemia include sodium sulfate, mithramycin, thyrocalcitonin, and methotrexate. Of these agents, sodium sulfate has yielded the most promising results. Sodium sulfate infusion was first used by Wolf and Ball in 1950. They noted an increase in urinary calcium after sodium sulfate diuresis in dogs. Chakagian *et al* popularized the treatment in 1965 when they reported on twelve patients who had a fall in serum calcium from an average of 12 mg% to 9 mg% after three liters of sodium sulfate solution were given over a nine hour period.[6]

The mechanism of sulfate action is believed to be (1) increased glomerular filtration, thus increasing calcium ion to renal tubules, (2) substitution of calcium ion for sodium ion at the renal tubules, and (3) electrostatic effect yielding a nonreabsorbable calcium sulfate complex.[6]

Objection to the use of sodium sulfate is that high sodium content may cause congestive heart failure.[7] Furthermore, Kahil found the hypocalcemic effect of sulfate lasted only 72 hours. In the same patients, use of hypophosphate solution re-

sulted in a hypocalcemic effect lasting up to two weeks after infusion.[7]

In emergency cases ethylene diamine tetra-acetic acid (EDTA) may be used. However, EDTA is nephrotoxic and its hypocalcemic effect is fleeting.

Still in the state of investigation are (1) mithramycin, (2) thyrocalcitonin, and (3) methotrexate. Mithramycin is an anti-tumor agent. It appears to block the action of Vitamin D on bone and gut, and may block the action of parathormone on bone. Thyrocalcitonin, the thyroid blood calcium lowering hormone, acts by preventing resorption of bone. Recent reports indicate the hormore has limited usefulness.[7] Methotrexate was found to reduce the serum calcium level in a patient with lymphosarcoma. It was believed the tumor was synthesizing a parathormone-like substance. Further experience is lacking.

Summary

This article presents a review of the treatment for hypercalcemia in malignancy. Special attention is given to use of intravenous and oral hypophosphate in a patient with severe hypercalcemia secondary to bone metastases from a thyroid carcinoma. Other agents and modes of therapy are discussed.

Bibliography

1. Anderson, J., Harper, C., Dent, C. E., and Philpot, G. R.: Effect of Cortisone on Calcium Metabolism in Sarcoidosis with Hypercalcemia. Lancet, V. 2, p. 720-724, Oct. 9, 1954.
2. Shackney, S. E., and Hasson, J.: Precipitous Fall in Serum Calcium, Hypotension and Acute Renal Failure After Intravenous Therapy for Hypercalcemia. Annals of Internal Medicine, V. 66, p. 906-916, May, 1967.
3. Goldsmith, R. S., and Ingbar, S. H.: Inorganic Phosphate Treatment of Hypercalcemia of Diverse Etiologies. New England Journal of Medicine, V. 274, p. 1-7, Jan. 6, 1966.
4. Goldsmith, R. S., and Ingbar, S. H.: Hyper to Hypocalcemia. New England Journal of Medicine, V. 274, p. 284, Feb. 3, 1966.
5. Massry, S. G. et al: Inorganic Phosphate Treatment of Hypercalcemia. Archives of Internal Medicine, V. 121, p. 307-312, April, 1968.
6. Chalnakjian, Z., and Bethune, J. E.: Sodium Sulfate Treatment of Hypercalcemia. New England Journal of Medicine, V. 275, p. 862-869, Oct. 20, 1966.
7. Kahil, M., et al: Hypercalcemia: Experience with Phosphate and Sulfate Therapy. Journal of the American Medical Association, V. 201, p. 721-724, Sept. 4, 1967.

Inositol hexaphosphate — Rencal

Prednisone — Delta-Dome, Meticorten



MONTHLY SURVEILLANCE REPORT
CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FOUR-WEEK PERIOD ENDING NOVEMBER 30, 1968

	1968 This 4-Week Period	1967 Same 4-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	21	35	317	1005
Whooping Cough	30	83	408	988
Diphtheria	0	0	0	1
Mumps	561	1579	14106	15682
Scarlet Fever & Strep Sore Throat	755	1003	9210	12051
Tetanus	0	2	3	5
Poliomyelitis (Paralytic)	1	0	3	3
Hepatitis	218	135	2118	1793
Salmonellosis (Other than S. typhi)	32	45	577	550
Thphoid Fever (S. typhi)	0	0	0	8
Shigellosis	28	17	286	390
Aseptic Meningitis	18	14	252	84
Encephalitis	8	5	97	102
Meningococcic Meningitis	10	8	88	72
Influenza Meningitis	8	4	60	54
Tuberculosis	158	267	2509	2759
Syphilis	426	456	5019	5246
Gonorrhea	1493	1544	16768	15927

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

More Drugs Mean More Problems In Managing Diabetes Mellitus

BY JOHN B. BRYAN, M.D., F.A.C.P.
ROYAL OAK

Pharmacologic interplay between the many drugs currently used in the management of a diabetic may result in deleterious effects, as well as intended or serendipitous benefits. In general, patients with diabetes use more drugs than most people because of their increased morbidity. A recent study of the frequency of significant side effects to drugs showed a direct relationship with prescribing of multiple agents.[1]

It follows then that caution must be exercised in treating diabetes and concomitant diseases. Particular care is needed in the aging, who have disorders demanding aid and relief, but who also have decreasing tolerance to standard doses of drugs.

As an example of this problem, profound hypoglycemic reactions, with neurologic manifestations mimicking classic cerebral vascular accidents, often presenting as stupor or coma, can be induced by sulfonylureas. Sanders observed such reactions to tolbutamide (Orinase) in an aged population of a large retirement home.[2] I am unable to document such an experience with Orinase in a large practice serving many with diabetes, but have seen severe hypoglycemia produced by chlorpropamide (Diabinese) and acetohexamide (Dymelor). I have observed too few patients using tolazamide (Tolinase) to have seen iatrogenic hypoglycemia when recommended doses are prescribed.

Little problem has existed in younger persons who have achieved adequate control of diabetes with rather large doses of sulfonylureas combined with a biguanide (timed-dispersed capsules of phenformin). In one instance a 37-year-old male tolerated what is generally considered huge doses, without subjective distress from hypoglycemia, gastrointestinal or cutaneous symptoms. He medicated himself daily with; 1) Dymelor 1.0 gm three times daily; 2) TD caps DBI 50 mg. before breakfast and supper; and 3) Diabinese 500 mg. before breakfast and supper and 250 mg. before lunch. This dosage is never recommended.

Recently I observed the accidental production of severe hypoglycemia by phenylbutazone (Alka-Butazolidin) potentiating the effect of Dymelor in a maturity-onset diabetic. The phenylbutazone was given for post-operative superficial thrombophlebitis in the leg of a 56-year-old female who had extensive hepatic metastases from breast carcinoma. Clinical evidence of hypoglycemia, with paraesthesias of hands and mouth, slurred speech and general depression of mentation appeared 48 hours after initiation of 100 mg. Alka-Butazolidin four times a day. A random evening blood sugar was 43 mg. per 100 ml., and despite discontinuing Alka-Butazolidin promptly, a fasting blood sugar the following morning was still 51 mg. per 100 ml. In two days without her usual dose of Dymelor (500 mg. each morning), normoglycemia returned and the latter drug was resumed alone.

A number of other drugs have been observed to potentiate the blood-sugar-lowering action of sulfonylureas. There seems to be a dose relationship. In part, the response depends on whether the metabolite of the sulfonylurea is able to lower the blood sugar. Some agents compete with sulfonylureas for binding with serum proteins, allowing more "free" sulfonylurea to act longer as a beta-cytotropic stimulus to release insulin. Examples of such, in addition to phenylbutazone are: Salicylates, sulfaphenazole, warfarin, bishydroxycoumarin and other coumarin-derivatives. Furthermore, other agents, such as clofibrate (Atromid-S) and phenyramidol hydrochloride (Analexin) inhibit the metabolism of warfarin (coumarins) and increase their anticoagulant and potential hypoglycemic effect.[3] All other drugs able to accentuate the anticoagulant effect of coumarin drugs theoretically have the same potential of accentuating the hypoglycemic action of the sulfonylureas. These include anabolic steroids, broad-spectrum antibiotics, dilantin, methylthiouracil, quinine and quinidine, radioactive compounds and d-thyroxine.[4]

In addition to competing for protein-binding, any agent which impairs liver or renal function or both as well as directly alters the metabolism of sulfonylureas may induce hypoglycemia or toxic side effects. The uricosuric agent, probenecid (Benemid), can interfere with the tubular excretion of the metabolite of tolbutamide, carboxy-

tolbutamide. Alcohol ingestion, particularly after prolonged fasting, as pointed out by Madison and Freinkel,[5] induces hypoglycemia. An interesting and discomforting side effect, apparently without hypoglycemia or lasting ill effects, occurs in some individuals taking sulfonylureas shortly after drinking alcoholic beverages. The amount of alcohol needed to produce the disulfiram-like reaction (i.e. flushing, dizziness, nausea, headache, tachycardia and apprehension) seems to be very little and is more profound with high doses of the sulfonylurea. In my experience this reaction occurs most frequently with chlorpropamide.

Some of the monoamine-oxidase inhibitors used as psychotropic or antihypertensive agents have been reported to potentiate sulfonylureas. In addition, Tofranil alone and in combination with sulfonylureas and insulin has been noted to lower blood sugar by an unknown action.[6] Very limited trials have suggested to me that this effect may be controlled to achieve psychotherapeutic benefits as well as euglycemia and aglycosuria. The action on the latter appears to be dose-related.

Though a recent report indicates large doses of phenothiazine over a period of a year or longer may produce hyperglycemia and glycosuria,[7] another paper published about the same time reports severe hypoglycemia occurring when Thorazine and Disipal (orphenadrine, Riker, a parasympatholytic and antitremor agent) were given together, in standard doses, to one patient, not known to be diabetic and not on blood-sugar-lowering agent.[8]

Though others have reported hypoglycemia during the use of isoniazid for at least a year, in "positive-reactors" to tuberculin skin tests, I have not observed it in several patients taking INH and insulin or sulfonylureas.

Skin rashes from sulfonylureas have not been a problem in my experience, occurring in less than 1% of my patients. One did develop a light-sensitive eruption, while on Diabinese.[9] I have been unable to find a single person reputed to be "allergic to sulfas" who could not tolerate a sulfonylurea.

Certain drugs, used widely in diabetics with various concurrent disorders, lessen the desired blood-sugar-lowering effect. These converse actions on the control of diabetes mellitus — by diet alone, or in combination with insulin or sulfonylureas or biguanide — must be reviewed, as a reminder. Notable, as likely the most frequent, is the diuretic family, particularly the thiazides, occasionally furosemide (Lasix) and ethacrynic acid (Edecrin), presumably due to their kaliuretic action producing hypokalemia, which results in an obtunded release of insulin from the beta cells. High doses of nicotinic acid, used to lower serum lipids, has decreased glucose tolerance. The glucocorticoids and many of the synthetic analogues predictably decrease the effect of insulin, either endogenous or exogenous, and increase the need for the latter or for oral agent (s).

Lack of unanimity of opinion exists regarding the effect of the anovulatory agents containing estrogens and progesterone on carbohydrate metabolism. One study showed a decreased glucose tolerance in a large number (46%) of women using these agents for 4-12 months. However, other authors have found few problems when estrogens or oral contraceptive drugs are used in diabetic women; this has been my experience.

SUMMARY

I have briefly discussed the currently-recognized adverse actions which can arise in managing the diabetic with the multiple-drug regimens necessary for care of concurrent disorders. Caution must be observed in prescribing these new agents, particularly when the patient is using a sulfonylurea agent, so that one avoids the induction of severe hypoglycemia by "potentiating" its blood-sugar-lowering action.

Problems in keeping hyperglycemia and glycosuria under control due to drugs that raise blood sugar are reviewed, particularly in regard to diuretics, steroids or anovulatory agents.

BIBLIOGRAPHY

1. Cluff, L. E., *Hosp. Pract.*, Sept., 1967.
2. Sanders, J. F., *J. Mich. St. Med. Soc.*, 62:1208, Dec., 1963.
3. Hunninghake & Azarnoff, *Arch. Int. Med.* 121:349 (April) 1968.
4. *Clin-Alert*, #103, May 8, 1968.
5. Arky, R., & Freinkel, N., *Arch. Int. Med.* 114:501 (Oct.) 1964.
6. Kaplan, S. M., Pixley, J. M., Ross, W. D., *JAMA* 174:511, (Oct.) 1960.
7. Thonnard-Neumann, E. *Am. J. Psychiatry* 124:978 (Jan.) 1968.
8. Buckle, R. M., & Guillebaud, J., *Brit. MJ* 4:599 (Dec.) 1967.
9. Hitselberger, J. F., & Fosnaugh, R. P., *JAMA* 180:62 (April 7) 1962.



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

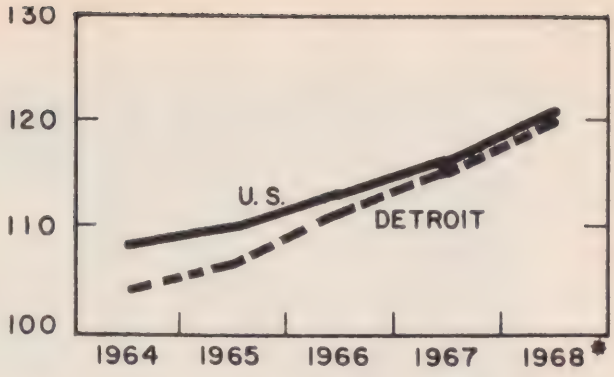
You might also say that all interns aren't alike, either.



PATIENT REPRESENTATIVE HELPS EACH PERSON

For each patient entering the University Hospital in Ann Arbor, such concerns as admission, health insurance and additional financing are now handled by a "patient representative" assigned to him. The same representative helps the patient with insurance reports, arranges for future settlement of his account, if necessary, and discharges him when he is ready to go home.

The system reportedly has helped modernize the hospital's entire business procedure, including data processing, insurance, credit collections and patient financial records. Hospital staffers say the program's greatest advantage is that it establishes a personal and confidential relationship for the patient in the big and often baffling hospital environment.



As the consumer price index chart indicates, Metro-Detroit enjoys a lower index for all items than that for the entire nation. The gap in recent years has narrowed. The figures include the July 1968 index of 121.5 (1957-59 = 100), putting the purchasing power of the dollar at 82 cents.

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan — MU 5-8441

Edwin M. Williamson, M.D.
M. Leroy Barry, M.D.

Dan W. Everett, M.D.
Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

Increase Practice Control Through MANAGEMENT By

Modern office and financial management offers realistic methods toward achievement of personal life goals. A logical outcome of PM's services is the attainment of your objectives.

OBJECTIVES

- More Time for Patient
- More Time for Leisure
- Better Collection Control
- Better Cost Control
- Assistance With Financial Planning
- Identify Business Problems
- Seek Best Solutions to Problems

PROFESSIONAL MANAGEMENT
Black and Skaggs Associates, Inc.
Battle Creek, Michigan

Serving Michigan Physicians

Offices in these cities
Ann Arbor - Battle Creek - Berkley - Detroit - Flint
Grand Rapids - Lansing - Muskegon - Saginaw - Traverse City



This isn't the end of the line.

(New TUBEX® are constantly being added)



Only TUBEX® offers so complete a line of closed system injectables

and it's still growing.

To meet your present needs more precisely, the Tubex line comprises 37 different products in 69 dosage variations. And more are on the way.

Tubex offers these unit dose advantages:

- **accuracy**—premeasured, clearly labeled to help ensure correct medication
- **convenience**—no filling, no needle-sharpening, no sterilization, no cleanup
- **simplicity**—precision-made, well balanced syringe breech loads in seconds, permits easy aspiration
- **reduces risk**—single-use cartridge-needle units reduce risk of cross contamination; less chance of spillage reduces risk of contact sensitization for doctor or nurse
- **stability**—glass cartridges can't deteriorate or react with medication
- **acceptability**—presharpened, siliconized needles lessen pain of injection; patients appreciate single-use equipment

Just select, inject, throw away

TUBEX®

sterile cartridge-needle unit

Wyeth Laboratories Philadelphia, Pa.

Wyeth®

UD UNIT DOSE MEDICATION



Robert J. Mason, M.D., MSMS President-Elect and Co-Chairman of the Michigan Citizens Committee on Medical Manpower, gave the major address at the metropolitan-area conference.



James J. Lightbody, M.D., MSMS President, presided at the MSMS Medical Manpower Conference at Bloomfield Hills December 12 for 50 civic leaders and county medical officers.



Warren M. Huff, of Plymouth, Co-Chairman of the Michigan Citizens Committee on Medical Manpower, thanks MSMS for its leadership in tackling medical manpower problems.

Urge State to Train More Physicians

A portion of the Southeastern Michigan civic leaders and physicians listen at the Bloomfield Hills conference to medical statesmen plead for more medical school graduates.





Dean Ernest Gardner, M.D., outlined expansion plans for the WSU Medical School. U-M Dean William N. Hubbard, Jr., M.D., was unable to attend.



William Weil, M.D., represents Dean Andrew D. Hunt, Jr., M.D., to describe growth plans of the MSU College of Human Medicine.



THE TV NEWS CAMERA grinds away for a long shot at the Grand Rapids regional medical manpower conference, attended by community leaders and county medical society officers from western and central Michigan. The need for more physicians was stressed in the address by Kenneth H. Johnson, M.D., MSMS Secretary.

Wanted: More Doctors





PHYSICIANS AND COMMUNITY LEADERS from Western Michigan discussed the critical need to train more doctors and to meet the community demands for more doctors in Michigan. Left to right are R. M. Gillett, Grand Rapids banker; S. C. Penzotti, M.D., Three Rivers; John Suerth, president of Gerber Products, and H. V. Sanden, M.D., Muskegon.

MSMS WAS LAUDED for its efforts to stress the need to educate more doctors at the three medical schools by Warren Huff, at far left, who is co-chairman of the Michigan Citizens Committee on Medical Education. Center is John A. Doherty, Michigan Health Council executive director. The photo is from the Grand Rapids meeting.



SCHOOL COUNSELORS, hospital administrators, leaders of volunteer health groups and others participated in the Michigan Conference on Medical Manpower at the MEA Center. A portion of the 200 registrants are shown listening to speeches by representatives of MSMS, medical schools, community colleges, hospitals, and others.



AT RIGHT, health careers recruitment program is being developed by the Michigan Health Council which recently received a $77,506 grant from the W. K. Kellogg Foundation for a three-year period. Directing the project will be John A. Doherty, left, MHC executive director, and Richard U. Byerrum, MHC careers chairman.

PROMINENT CITIZENS from southwestern Michigan joined physicians at the Medical Manpower Conference. Several legislators attended including Wayne B. Sackett, at far right foreground, of Portage, recently elected for a first term.











PROGRESS IN TRANSPORTATION is shown in these four photographs of Thomas LeRoy Peacock, M.D., a general practitioner who practiced in Sunfield from 1899 to 1918, and then in Lansing from 1918 to 1938. After he retired he moved to Lake Odessa where he died in 1948 at the age of 79. His daughter, Mrs. Fred Knudsen, of Lansing, recalls that although Doctor Peacock kept pace with improvements in transportation he always retained his fondness for the horse-drawn carriage. The pioneer Michigan doctor always said he preferred the horse and carriage on that return trip from a late night call . . . Doctor Peacock would sleep while the horse guided the vehicle home safely. (Photos, Courtesy of Lansing Historian Ford S. Ceasar.)



MSMS SPOTLIGHTED . . . The MSMS postgraduation education program providing fall and spring clinical programs and lectures in 20 centers was described by Harry A. Towsley, M.D., PG committee, at the recent AMA Conference on Continuing Education in Chicago to 100 representatives from state medical associations. The AMA selected Michigan, Utah and Oregon to explain their fine programs.



PHOTOS OF MASON COUNTY physicians are now on display in the Ludington Memorial Hospital. The Woman's Auxiliary to the Mason County Medical Society several years ago began a collection of photographs of former physicians as a contribution to its historical records — and then pitched in to get the photos of the current doctors. Left to right are Albert Paulus, hospital administrator; Harry Clark, M.D., county society president, and Mrs. Charles Paukstis, Auxiliary project chairman.

THROUGH THESE DOORS pass the world's best excuses for not using safety belts; what's your excuse? That message and the startling photograph are being used in many magazines to help the National Safety Council-Advertising Council campaign. The MSMS House of Delegates and committees on many occasions have urged every physician to set a good example and buckle up for safety.





REPRESENTATIVES OF the SAMA chapters at the University of Michigan and Wayne State University attended the 1968 House of Delegates as special guests. Left to right, seated in a reserved section, are: Joel Morganroth, U-M; Rose Marie Lucianin, WSU; and David Priver, WSU. MSU representatives were invited but were unable to attend.

In Many Ways, MSMS Seeks to Help Three SAMA Groups, Medical Students

Richard Kraft, M.D., Ann Arbor, is the current chairman of the MSMS committee that arranges lectures about socio-economic subjects for the University of Michigan students. C. Howard Ross, M.D., right, former MSMS committee chairman, several years ago helped MSMS host a number of U-M medical students at the MSMS headquarters.



While there are as many opinions about organized medicine as there are medical students, MSMS throughout the year is making constant efforts to insure that these opinions are informed and thoughtful through many attempts to encourage student participation in MSMS activities.

One of the major MSMS efforts is to invite about 15 students from the three medical schools to the Annual Session each year. Expenses are paid by MSMS and a special place is reserved for the students on the floor of the House of Delegates meeting. In addition, any interested senior medical students can participate in the scientific meetings free of charge.

AN ACTIVITY WHICH carries on throughout the year is a series of lectures and discussions for senior medical students at the University of Michigan. A committee of physicians and student representatives selects the topics and speakers, all of which focus on socio-economic and ethical matters to help round out the scientific curriculum of the medical school. Topics cover: "A History of Medical Ethics," "Establishing a Fee Schedule," "The Physician and the Law,"



KRAFT

"What the Physician Should Know About Insurance," "Placement Opportunities in Michigan," and many others.

Complimentary copies of *Michigan Medicine* are sent to all three medical schools for distribution to the students.

BESIDES BEING A sustaining member of the national SAMA organization, MSMS makes cash contributions to the three SAMA chapters in Michigan; an additional contribution was made this year to help support the National SAMA convention in Detroit.

The wives of medical students are also involved in organized medicine, largely through the efforts of the MSMS Woman's Auxiliary. Woman's Auxiliary to the Student American Medical Association representatives are regularly invited to state wide meetings such as the recent spring conference and legislative day held in Lansing by the Woman's Auxiliary.

The Woman's Auxiliary also sponsors "Operation Adoption," a program through which students, residents, interns and their wives are invited to the homes of local physicians.

THE WOMAN'S AUXILIARY helps with contributions to local and national WASAMA chapters and to the American Medical Association Education and Research Fund which provides loans to medical students.

Recently the MSMS Liaison Committee with Residents, Interns, and Senior Medical Students, in cooperation with Merck, Sharp, and Dohme pharmaceutical company, held an Office Management Seminar for new and prospective physicians during the Annual Session in Detroit.



A Seminar on Office Management was presented for medical students and new physicians by Norman Henderson, M.D., third from left, and the MSMS Liaison Committee with Residents, Interns and Senior Students at the 1968 Annual Session.

Medical students from the new Michigan State University College of Human Medicine were guests of MSMS for a program and dinner. Herbert Mehler, standing, of the MSMS staff, explains the new Comprehensive Health Care legislation and plans in Michigan.





Claude L. Weston, M.D., right, was pleased and surprised when the 1968 House of Delegates adopted a resolution honoring him for 26 years of service in the House. The Owosso doctor scans the formal document with Speaker James B. Blodgett, M.D.

House of Delegates Acclaims Owosso Doctor For 26 Years of Consecutive Service

For 26 consecutive years, Claude L. Weston, M.D., of Owosso, has represented his Shiawassee County Medical Society on the MSMS House of Delegates. And he has had 100 percent attendance. No other present member can claim this honor.

Therefore, at the recent 1968 House of Delegates meeting in Detroit Resolution #66 was adopted by acclamation, commending the 72-year-old doctor for his "highly unusual and outstanding contribution to both his colleagues and the Society as a whole."

The resolution lauded Doctor Weston for representing his county medical society "faithfully and effectively." The delegates expressed their "deep admiration and appreciation" for Doctor Weston.

The resolution, which cited Doctor Weston, pointed out the contributions of all delegates. In part, it declared that delegates "accept the responsibility of representing their constituent fellow physicians, thereby performing a vital service to their society and participating in the shaping of the course of the Michigan State Medical Society. Such physicians, like Doctor Weston, who serve as delegates, the resolution stated "give of themselves, give their valuable time and energies to the ultimate benefit of the profession and the people of Michigan."

The resolution was introduced by Speaker James B. Blodgett, M.D.

Doctor Weston was graduated from St. Louis, Mo., University Medical School and took postgraduate study in radiology.

He is a former chief of staff at The Memorial Hospital, Owosso, and is a member of the Radiological Society of North America.

Doctor Weston has also been a member of the board of directors and executive committee of the Michigan Division, American Cancer Society.

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

Valium®
(diazepam)



To help break the cycle of skeletal muscle spasm

Six years of investigation have culminated in the recognition of Valium (diazepam) as an effective muscle relaxant—in addition to its distinctive role as a calmative in psychic tension.

Used adjunctively, Valium acts to relieve reflex spasm of skeletal muscle due to local pathology, such as trauma and inflammation.

To break the cycle of spasm/pain/spasm
Muscle trauma or inflammation can trigger involuntary spasm or "splinting" of muscle, and the resulting discomfort further aggravates the spasm; thus a vicious cycle of spasm/pain/spasm is produced.

To help increase range of mobility
Valium helps break this cycle of reflex spasm to local pathology—with these benefits: relief of discomfort as spasm is relaxed, increased range of mobility, faster return to more normal activities.

To relieve psychic tension when also present
When psychic tension or anxiety complicates the clinical picture of skeletal muscle spasm, the widely-recognized calming action of Valium may also contribute to total patient management.

(Artist's conception of reflex arc.)



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

2-mg, 5-mg, or 10-mg tablets, t.i.d. or q.i.d. and when skeletal muscle spasm and psychic tension interfere with sleep: add 1 tablet, h.s., to t.i.d. dosage

Roche® LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Public Enema No.1





Claim the rewards of sparing your patients the tubes and tribulations of unpleasant enemas.

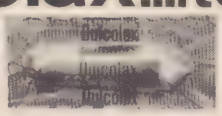
Compared to enemas, Dulcolax suppositories are a gentler and simpler way to empty the bowel. Gone are the tubing, the "accidents", and the bruised egos. Just one suppository, inserted against the bowel wall, usually brings about an evacuation within 15 minutes to an hour.

In the hospital, order Dulcolax for constipation or bowel cleansing. Your patients will often prefer it to embarrassing enemas. And you can be sure nurses will appreciate the saving in time and effort.

Dulcolax tablets taken at night usually result in a bowel movement the following morning. A combination of tablets at night and a suppository the next morning generally cleans the bowel thoroughly in preparation for surgery or special procedures. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable

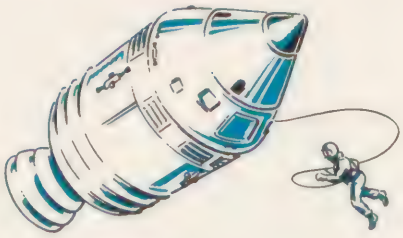
bisacodyl



Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York 10502

DU-611



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



When the pink pill for U.R.I. symptoms speeds into action, someone somewhere breathes easier.

You provide prompt and continuous relief from symptoms of U.R.I. when you prescribe Novahistine Singlet. Novahistine Singlet is formulated to quickly relieve the fever and the aches and pains that so frequently accompany upper respiratory infections. And these continuous-release tablets provide a vasoconstrictor-antihistamine formulation to shrink swollen membranes and reduce congestion of the turbinates and sinuses.

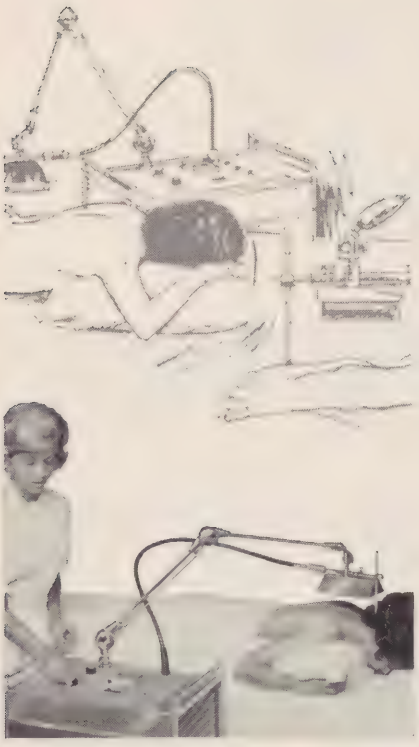
A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana

Novahistine®
Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW



Effective yet simple to operate

Burdick's smartly styled MW-200 Microwave Diathermy affords effective deep tissue* heating – conveniently and quickly. **Features:** Simplicity of operation / Ease of director placement / Counterbalanced fully adjustable arm / Flexible coaxial cable / Single power control with automatic timer / Easy mobility / Modern styling / Quality-engineered for years of dependable service.

Liberal trade-ins are now being offered by your Burdick dealer. Take a good look at your present diathermy equipment.

*Up to 7.81° F. at a depth of 5 cms.

THE BURDICK CORPORATION
MILTON, WISCONSIN 53563

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit, Michigan 48201
Telephone: TEmple 2-4444

MSMS Members In the News

Herbert A. Raskin, M.D., Detroit,
recently was appointed to the executive council of the National Coordinating Committee on Drug Abuse Education and Information, representing the American Psychiatric Association.

John R. McDonald, M.D., Detroit,
received the Papanicolaou Award of the American Society of Cytology at its recent annual meeting in Cleveland. Doctor McDonald is head of the department of pathology at Harper Hospital and professor of pathology at WSU.

Robert Fles, M.D., Muskegon,
has completed his term as president of the Blue Lake Fine Arts Camp Board of Directors. He will remain on the executive board.

Richard J. Bing, M.D., Detroit,
chairman of the department of medicine at WSU, has been invited to the University of Montreal Institute of Experimental Medicine and Surgery in January as the Claude Bernard visiting professor. This honor is one usually reserved to Nobel Prize laureates.

C. Ford DeVries, M.D., Lansing,
was honored recently by a gathering of Lansing area pilots at the Capital City Airport. The special program was arranged for Doctor DeVries upon his retirement after nearly 30 years as a Federal Aviation Administration medical examiner.

John H. Bethea, M.D.,
director of the alcoholism programs at Maybury Sanitorium in Northville until recently, is now medical director of Brighton Hospital in Brighton. Donald L. Damstra, M.D., former hospital director, has entered private practice in Phoenix, Arizona.

Several Grand Rapids doctors
serve on the board of directors for Sinfonia, the new Grand Rapids chamber orchestra. The board includes Keats K. Vining, M.D., Robert Marshall, M.D., Judith Meyer, M.D., Leonard Rosenzweig, M.D., Carl List, M.D., and Albert Kempter, M.D.

ROSELAWN MANOR
A Convalescent - Retirement Residence for Senior Citizens

Offering complete convalescent care with a complete staff of nurses and attendant personnel for every need in 220 units.

707 ARMSTRONG RD., LANSING, MICH. 48910
Phone 393-5680

Two good reasons to specify LEDERCILLIN® VK

Potassium Phenoxymethyl Penicillin

1. It's a Lederle product.
2. Low price.

Tablets:
250 mg—100's and 1000's
For Oral Solution:
125 mg/5 cc—80 cc and 150 cc
250 mg/5 cc—80 cc and 150 cc

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

9-7-1041/461-9

NEW



Perhaps no single factor in the modern history of Medicine in Michigan is as important a force in medical economics as Michigan Blue Shield's conversion of its programs to the new "MVF," or Michigan Variable Fee, plans. That conversion is now approximately 80 percent completed. **Michigan Medicine** has asked Blue Shield to prepare a series of articles to explain the exact workings and implications of the plans.

This first article, by Louis F. Hayes, M.D., Michigan Blue Shield Vice President-Medical Affairs, and Neal L. McCue, Vice President-Professional Relations, deals with fees themselves. Others in the series will be concerned with interpretations of benefits and exclusions, physician participation and medical care costs.

Explanation of Michigan Blue Shield Variable Fee Payment Mechanism

By Louis F. Hayes, M.D.
Neal L. McCue
Michigan Blue Shield

In the past year, Blue Shield has exerted considerable time and effort to describe and explain in detail the Variable Fee payment mechanism. Blue Shield representatives have attended in the past year 115 County Medical Society meetings; made presentations to 36 County Society meetings and 48 specialty society or hospital staff meetings; attended 26 MSMS Councilor District meetings; made 18,499 personal contacts with physicians and conducted 30 formal seminars involving 4,022 medical assistants. Yet there are indications, in some physician quarters, that the mechanism is not clearly understood. Accordingly, the following information is presented:

I. Definitions

Three terms are vital to the understanding of the Variable Fee payment mechanism. These are: "customary," "prevailing," and "reasonable." **These three terms were defined by the Michigan State Medical Society House of Delegates** at its 1966 session by Resolution Number 16. These definitions are being followed by Blue Shield in the implementation of the Variable Fee Program. They are:

Customary: relates to the individual physician and the charge which he most commonly establishes as fair compensation for specific services.

Prevailing: relates to the range of usual charges made by physicians of similar ability and experience for the same service within the same specific socio-economic limited geographic area.

Reasonable: a fee is "reasonable" when it meets the "customary and prevailing" criteria or, in the opinion of a duly constituted medical society committee, is justified under what is considered a complexity of treatment which merits special consideration.

II. Customary Profiles And How They Are Compiled

For each physician who reports services, Blue Shield compiles a list of the **actual charges** by procedure as indicated on the reporting form submitted by the doctor. After a statistically valid number of charges are assembled for each procedure from the doctor, a mode charge is established, i.e., the charge which he most frequently

makes for a particular service. It is important to note that in no way is the physician's customary charge profile established on the basis of payments made for services.

Example: Doctor A	Service — Appendectomy
10 charges at $125.00	40 charges at $150.00
5 charges at $175.00	1 charge at $200.00

"Customary" charge = most common charge = $150.00

III. How Customary Charges Are Changed

If, for valid economic reasons, a physician later finds that his customary charge for a particular procedure is no longer appropriate, he may change it in his customary charge profile by filing with Michigan Blue Shield a **ninety-day written notice**, but not more than **once in any 12-month period.** The notice should indicate the exact procedure (s) involved, his present charge (s) for the procedure (s), and the new charge (s) he wishes to make, together with reasons for the charge (s). During the ninety-day period, Blue Shield will process his revised customary change against his profile record as well as against the current prevailing range of fees for the procedure, and ultimately, advise the doctor whether or not it is within the prevailing range. At the end of the ninety-day notice, Blue Shield will update the physician's customary profile record to reflect the new charge as ultimately agreed. As long as the new customary charge is within the current prevailing range of fees for the procedure, or if the participating doctor agrees to accept the then current prevailing screen should the new customary charge exceed the range, he may continue to participate and receive payment directly from Blue Shield.

IV. How Prevailing Fee Ranges Are Compiled

The prevailing range of fees, the top level of which is sometimes called the prevailing "**screen,**" is a function of the customary charges of physicians. The prevailing range is composed of all customary charges, by similar physicians, in the same socio-economic area, that have been reported for a given procedure.

Example: Area X	Service — Appendectomy			
	$125.00	$150.00	$175.00	$200.00
Doctor A	10	40	5	1
Doctor B	—	10	50	10
Doctor C	—	—	100	—

"Prevailing" charge = $175.00

The prevailing fee is determined:

Fee	No. of Serv.	Accum.	% of Serv.	Accum.
$125	10	10	4.4	4.4
$150	50	60	22.0	26.5
→$175	155	215	66.5	95.0←
$200	11	226	5.0	100.0

(The prevailing screen is that fee that will pay at least 90% of the charges in full.)

Specific Examples: Customary	Service — Appendectomy Prevailing — Area X
Dr. A — $150; Dr. B — $175	$175

	Dr's. Charge	MVF Pays	Reason
Doctor A	$125	$125	Charge is Dr's. customary & is within prevailing level
	150	150	
	175	150	Charge exceeds Dr's. customary
Doctor B	150	150	Charge is Dr's. customary & is within prevailing level
	175	175	
	200	175	Charge exceeds Dr's. customary & the prevailing level

Blue Shield is committed to review at least annually the range to be certain that it **currently reflects the pattern of charges for** each procedure in the area. Only the latest twelve months of charge data are retained and data over twelve months is dropped. During this early period of the Variable Fee system, the prevailing range is being reviewed quarterly.

V. Shifts in the Prevailing Screens

It should be noted that the review process for charge patterns and prevailing screens used in the Medicare program will be adapted to the MVF program. In this connection, it should also be noted that this technique has already produced **three upward revisions in the screen levels** in the government program. As more and more claims are received on Michigan Variable Fee Contracts, the charge data will be more all inclusive, particularly in areas of service not so prevalent for Medicare-Medicaid patients. In the absence of sufficient charge data to produce a statistically valid prevailing range, Blue Shield will continue to use such guidelines as MRVS, etc.

VI. Socio-Economic Areas

In planning for Variable Fee-type payments, Blue Shield determined from demographic studies (including one by MSMS) that charges by physicians are not necessarily uniform in all areas of the state. The MSMS study disclosed that while there were eleven distinct charge patterns in Michigan, they generally feel into four socio-economic or geographic regions. There were exceptions, but so slight in terms of average charges and fee ranges that Blue Shield felt that the four areas it uses to administer Variable Fee payments is equitable to all concerned.

Area 1 — Wayne, Oakland, Macomb, Washtenaw counties
Area 2 — All counties in Lower Peninsula containing cities of over 50,000 population.
Area 3 — All other counties in Lower Peninsula
Area 4 — Upper Peninsula

There has been some misunderstanding regarding the effect on payment levels of the area in which a physician practices. It does not necessarily follow that fees in Area I, for example, will be higher than in Area II, III and/or IV. The con-

verse is also true. Individual fees, or course, are a product of the charge pattern of the physicians in the area as noted in the description above concerning prevailing ranges. In some instances, Blue Shield has found that fees are higher in Area IV than in Area I. Likewise, there are those procedures in which charge levels do not vary in any of the areas of the state.

VII. Doctor Participation and Variable Fee Payments

Payments for services by formally **participating** physicians will be paid directly to the physician. They will be "tested" in our computer programs against his customary charge as well as against the prevailing range or "screen" then in effect.

Payments for services by **non-participating** physicians will be determined in exactly the same manner used for the participating physician, but payment will be directed to the patient. For the time being, a non-participating physician may elect to participate on a per-case basis by using the "Pay Doctor" reporting form instead of the "Pay Subscriber" form. When the non-participating physician does use the "Pay Doctor" claim form, he will receive payment directly and be under the same obligations as a participating physician in terms of not charging additionally for covered services.

VIII. Unusual Cases and Appeal Mechanism

It is recognized that (1) all cases are not "normal" and (2) because of medical complications and other special situations, a doctor's charge may not be the charge he customarily makes if the procedure or service were "normal." In such a case, the physician may request **"Individual Consideration (I.C.)"** and document, on the claim form or an attachment thereto, full details regarding the service and the reason his charge differs from his customary fee for the service. With these additional medical facts, the case receives individual consideration by the various medical consultants inside and outside of Blue Shield. **In order that a physician's customary charge profile and the prevailing range of fees is not distorted, charge data, in such "I.C." cases, is omitted from them.**

If a physician believes a particular fee, as determined by the customary and reasonable charge mechanism, is not satisfactory for a particular service, he should advise Blue Shield as soon after the fact as possible. It is suggested that, in the best interests of his patient and himself, the non-participating physician not issue a final billing to the patient until the review has been accomplished. If the basis for the dissatisfaction is medically valid based on peer review and reasonable charge criteria, then appropriate adjustments in payment will occur. The number of "stages" involved in the review process include: Internal Medical Consultants in the Medical Affairs Division; outside special Medical Consultants contacted by the Medical Affairs Division; and Regional Review Committees of independently appointed physicians. The nature of the circumstances involved in a particular case would determine to what degree these various mechanisms are involved. As is true for all claim submissions, final responsibility lies with Blue Shield Claims Administration Division.

Blue Shield is prepared to accept the decision reached in the total process based on the actual facts, although ultimate and final responsibility must rest with Blue Shield if it is to remain fiscally responsible to the medical profession, the subscribers and the public in general.

CO-AUTHORS



HAYES



McCUE

IX. Blue Shield Fiscal Responsibilities

With over 200 million dollars in benefits being paid out annually, it would be untenable for Blue Shield to consider all charges by physicians to be reasonable automatically and merely issue checks based on bills submitted. We must remain closely attuned to the various charge patterns that are constantly emerging to determine why such changes occur, and if they are the results of natural causes or because of interference of an inappropriate source. Some fee excalation has been noted in specific areas which gives rise to serious concern if such movement is not based on prudent and responsible medical judgment. In any case, Blue Shield must have a screening and review process which provides equity and assures all those to whom it is responsible that its programs are being administered responsibly.

Businessmen Would Balance Nat'l Budget

Nearly nine out of 10 independent business and professional men in Michigan say they favor a completely and continuously balanced Federal budget, according to a poll conducted by the National Federation of Independent Business.

In Michigan, and the nation, 89 per cent said they favor the proposition, 8 per cent oppose it, and 2 per cent are undecided.

According to the Federation, businessmen feel that a balanced budget is essential to solve the country's mounting problems of tax burdens, inflation, lack of confidence in the dollar, high interest rates and economic uncertainty. Many of the business and professional men said they see inflation as a direct result of government policies that have brought eight years of uninterrupted Federal deficits and a $25.4 billion loss in the fiscal year just ended.

To achieve a balanced budget, the NFIB favors reductions in Federal spending rather than tax increases. This is indicated by their previous national vote of 90 per cent against the latest tax increase when it was originally proposed as a 6 per cent surtax.

ECONOMIC CLUB INVITES WILBUR

AMA President Dwight L. Wilbur, M.D., of San Francisco, Calif., has accepted an invitation to speak Jan. 13 to the Economic Club of Detroit. The Economic Club annually presents a speech by the AMA president.

Doctor Wilbur was in Detroit during November to speak at the annual convention of the American Public Health Association and at a staff meeting of the Bon Secours Hospital.

Three Universities Among Top 50 In Doctoral Degrees

The current issue of *American* Education, journal of the United States Department of Health, Education and Welfare lists the 50 universities which confer the largest number of doctorates.

The University of Michigan ranks 6th with 2,551 in the period 1960-1966; Michigan State University is 14th with 1,833 and Wayne State University 47th with 584.

Four universities had conferred over 3,000 each; in this order, University of California at Berkeley, 3,228; University of Illinois, 3,224; University of Wisconsin, 3,143; and Harvard, 3,057.

GRANT CONTINUED

A Public Health Service grant of $74,621 has been awarded to Wayne State University to continue the "Allied Health Professions Educational Improvement Program" under the supervision of Morton Levitt, M.D., associate dean of academic affairs of the WSU School of Medicine.

Three Doctors Named To Advisory Group On Sex Education

Three physicians have been named by the State Board of Education to serve on a committee to provide advice on sex education for Michigan schools.

The medical representatives include: Eleanor Skufis, M.D., Adrian; Harry Tarpinian, M.D., Livonia; and Irving Posner, M.D., Detroit.

The Michigan Youth Commission sponsored the bill, which was supported by MSMS and enacted by the State Legislature. A total of 25 persons will serve on the committee representing medicine, education, the ministry and other groups.

Primary function of the committee will be to help determine the most effective ways of assisting schools and colleges and universities in providing instruction, establishing libraries, developing educational programs for teachers and developing guidelines for sex education including those for family planning information.



in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android

Each yellow tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available: Bottles of 100, 500, 1000.

Android-HP

HIGH POTENCY

Each red tablet contains:

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available: Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.
Available: Bottles of 60, 500.

REFER TO PDR

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablet twice daily
Available: Bottles of 60, 500.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

also available with ESTROGEN

Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg.
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

INGRAM'S SERVICE DEPARTMENT

ALL FACTORY TRAINED MEN

We service Medical Equipment, Electrocardiographs, Basal Metabalors, Sterilizers, Autoclaves, Diathermy Outfits, Cutting Units, Ultra Violet Lamps, Hydro Therapy Units, Laboratory Equipment. ALL BURDICK, LIEBEL FLARSHEIM AND RITTER EQUIPMENT.

If you have any Service problems, please call us at TE 2-4444, ask for the SERVICE DEPARTMENT and we will gladly help in any way we can.

THE G. A. INGRAM COMPANY

4444 Woodward Avenue TEmple 2-4444 Detroit, Michigan 48201



Senokot

(standardized senna concentrate) TABLETS

SENOKOT Tablets help place simple, functional constipation in proper perspective. They don't dramatize the problem. They simply help relieve it.

Patients appreciate the gentle ease of laxation that is specific, predictable, comfortable. *Over 95% effective in thousands of reported cases.**

And SENOKOT Tablets won't disrupt the night with peristaltic rushes. Because the action is virtually colon-specific, gently stimulating peristalsis through Auerbach's plexus. Taken at bedtime, they generally induce comfortable evacuation of soft, well-formed stools the next morning.

When the sun is up. Not at 2 a.m.

Patients like economical, easy-to-take SENOKOT Tablets. So do physicians. That's why they have widely prescribed SENOKOT preparations for over a decade.

Dosage (preferably at bedtime): *Adults:* 2 tablets (max. 4 tablets b.i.d.).

Contraindication: Acute surgical abdomen.

Supplied: Bottles of 50 and 100 tablets.

**Bibliography on request.*

The Purdue Frederick Company
Yonkers, N.Y.

©COPYRIGHT 1967, THE PURDUE FREDERICK CO. E-206B67R



BRIGHTON HOSPITAL

A non-profit foundation

FOR ALCOHOLISM

Member, Michigan Hospital Association, American Hospital Association

A facility designed to rehabilitate and aid the compulsive drinker in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board.

12851 East Grand River
One block south of I-96 at Kensington Rd. Exit four miles east of U. S. 23
Brighton, Michigan
ACademy 7-1211

(A 16-m.m. sound color film on Brighton Hospital is available for free loan to qualified groups.)

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

DETROIT OFFICE: G. A. Triplett, R. K. Wind and J. K. Galloway, Representatives
27200 Lahser Road, Southfield 48075 Telephone: (Area Code 313) ELgin 3-4848 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative
422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477

MPHA Convention Invites Exhibits

A call has been issued for exhibits of materials and products at the annual convention May 7-9 in Flint of the Michigan Public Health Association.

The exhibits will be located in the lobby and on the mezzanine floor of the Pick-Durant Hotel, location of the three-day meet.

Those wishing to apply for exhibit space are asked to contact Mrs. Anna Lampela, executive secretary, Michigan Public Health Association, Inc., 2429 Delta River Drive, Lansing 48906.

GET INVOLVED PHYSICIANS TOLD

Physicians were given eight suggestions at the recent AMA Communications Institute on how the doctor can be effective in any group he has chosen to participate in. Darrell Coover, of the AMA Washington Office, urged every physician to become more active in civic affairs, by making these suggestions:

1. Each year get two speakers on health matters to address the group to which he belongs.
2. Get his group to distribute literature which is available from the AMA and medical societies.
3. Respond to specific criticisms which are made about the medical profession.
4. Encourage sound health articles in the publication of your group.
5. Get to know the leaders in the group.
6. Get to know who is active on various committees.
7. Get on the most effective committees in your group.
8. Try to gain key national positions.

Curtis Suggests Moving VD Clinics Into Hospitals

Arthur C. Curtis, M.D., professor emeritus of dermatology at the University of Michigan, suggests moving venereal disease clinics from public health departments to hospitals to help control the national VD epidemic.

At a national fall leadership conference on venereal disease in New York, Doctor Curtis told fellow American Social Health Association members that "the teaching of venereal diseases and their management receives so little attention in most schools of medicine that few, if any, students of medicine and nursing have ever seen a case of primary or secondary syphilis."

Doctor Curtis proposed that directors of the venereal disease clinics could easily be furnished by medical schools of hospitals. Short courses of VD diagnosis treatment and control could be given throughout the year, and the "lost generation of knowledgeable medical students and nurses regarding venereal disease would be dissolved."

DETROIT DOCTORS PRODUCING MOVIE TO RECRUIT YOUTHS

A color motion picture, being prepared by four Detroit physicians, will soon bring to light "Opportunities for Afro-Americans in the Field of Medicine."

Working on the film are three Wayne State University School of Medicine professors: Charles Vincent, M.D., Charles Whitten, M.D., Charles Wright, M.D.; and also William Bentley, M.D. The Detroit Medical Society and the International Afro-American Museum, Inc., are sponsoring this project to recruit more black students.

The Health Careers Mobile earlier this year helped recruit in the inner city.

MHC DIRECTOR ADDRESSES SMOKING CONCLAVE

The health professionals in America can, by influencing the smoking habits of most young Americans give them an additional eight years of good life and save them an estimated $8,000 during their lifetime to spend on the better things of life, said John A. Doherty at a recent national smoking and health conference in Miami Beach.

Mr. Doherty, executive director of the Michigan Health Council, and a keynote speaker at the meeting, delivered a paper titled "Health Professionals and Cooperative Action" before the conference general assembly.

Helen Schulte, MSMS staff member, attended as one of the Michigan delegation. Benjamin Yep, coordinator of the Michigan Council on Smoking and Health, and Mrs. Clio Van Valkenburg, Kalamazoo, American Cancer Society, were the other Michigan representatives.

New Exhibits for Careers Mobile

Three new exhibits will be developed for the Michigan Health Council's Health Careers Mobile while it is in "dry dock" during the worst of the winter weather.

Two of the displays will be about careers in medical research and rehabilitation and the third will be prepared by the University of Michigan.

The mobile made its final 1968 appearance Dec. 13-18 at Martin Luther King Junior High School in Detroit, which had scheduled a "Health Careers Day" Dec. 18.

IN MEMORIAM

Cyrenus G. Darling, Jr., M.D.
Pontiac

Cyrenus G. Darling, Jr., M.D., former chief of staff and chief of surgery at St. Joseph Mercy Hospital, Pontiac, died Nov. 22 in Pontiac at the age of 69.

Doctor Darling was graduated from the University of Michigan's medical school where his late father was professor of surgery. He was a former president of the Oakland County Medical Society and medical director for General Motors Corp.

He was a member of the Orchard Lake Country Club and the Old Club and was also on the staff of the Pontiac General Hospital and Beaumont Hospital, Royal Oak.

F. E. Robertson, M.D.
Southfield

F. Edward Robertson, M.D., Southfield, specialist in internal medicine, died Aug. 14 at the age of 42.

Doctor Robertson was graduated from the University of Michigan School of Medicine and was affiliated with Mt. Carmel Mercy Hospital in Detroit. He was a member of the Marine Historical Society of Detroit. He served with the Navy from 1944 to 1946.

Edward Mond, M.D.
Detroit

Edward Mond, M.D., longtime Detroit area physician, died Nov. 22 at the age of 67. He was born Nov. 28, 1900.

Doctor Mond, board certified in otolaryngology, was affiliated with Womens Hospital in Detroit. He was graduated from Wayne State University medical school in 1927. He was a member of the American Academy of Ophthalmology and Otolaryngology.

Sidney Milgrom, M.D.,
Huntington Woods

Sidney Milgrom, M.D., Huntington Woods, died Nov. 23 at University Hospital in Columbus, Ohio, at the age of 47.

Doctor Milgrom was graduated from the University of Michigan Medical School and practiced in Royal Oak.

A specialist in internal medicine, he was affiliated with Beaumont Hospital.

Ruth E. Wagner, M.D.
Royal Oak

Ruth E. Wagner, M.D., Royal Oak doctor for 45 years, died Nov. 23 at the age of 76.

Doctor Wagner, a general practitioner, studied at the University of Michigan School of Medicine and Detroit College of Medicine. She was affiliated with William Beaumont Hospital.

Miss Wagner was a member of the Chamber of Commerce, Business and Professional Womens Club, the Daughters of the American Revolution, and the Soroptimist Federation of the Americas.

Daniel Van Woerkom, M.D.
Grand Rapids

Daniel Van Woerkom, M.D., general practitioner in Grand Rapids for 38 years, died Nov. 28 at the age of 69.

A graduate of the University of Michigan Medical School, he was a member of the American Academy of General Practice.

He was a member 36 years of Central Reformed Church in Grand Rapids, where he served as a deacon and elder. A veteran of World War I, he served in France and received the Purple Heart.

Alfred LaBine, M.D.
Houghton

Alfred LaBine, M.D., who maintained a practice at Houghton for 56 years, died Nov. 11 at the age of 82.

Dr. LaBine obtained his medical degree in 1910 at the University of Michigan and did postgraduate work on cancer in New York City and Paris.

He became mine physician for the Winona Company in Houghton County after interning at the Calumet and Hecla hospital. He opened an office in Houghton in 1912 after becoming health officer for the county. He was the county health officer for 25 years.

Dr. LaBine was former president of the Houghton-Keweenaw-Baraga Medical Society, former president of the Upper Peninsula Medical Society, a fellow associate of the International College of Surgeons and dean of the staff of St. Joseph Hospital in Houghton.

He was a former officer in the Hancock-Houghton Council Knights of Columbus and the Bishop Baraga Fourth Degree Assembly, former president of the Houghton Rotary Club, sponsor of the Newman Club, and trustee on the board of the Good Will Farm.



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth®

Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

GENERAL SURGEON: Board Certified or Eligible; 269 bed, General Medical and Surgical Hospital in Michigan's Upper Peninsula. Licensure any state, salary dependent upon background and qualifications. Excellent benefits for retirement, vacations, sick leave, and professional improvements. Non-discrimination in employment. Contact Chief of Staff, VA Hospital, Iron Mountain, Michigan 49801.

GENERAL PRACTITIONER wanted. Top income immediately, no investment, no placement charge, hospital privileges assured. Ample office building owned by four GP partnership, with one retiring and another reducing practice. Southern Michigan city of less than 100,000 with golf, fishing, sailing and hunting nearby. On call one weekend in three. This ad is placed by the oldest management firm in the country. Write P.M. - B.C., Professional Management Associates, Incorporated, 181 North Avenue, Battle Creek, Michigan 49017.

FOR RENT: Office space in modern professional building on Lansing's far west side. Air conditioned with off street parking. Hospitals in city easily accessable from this location. Rent reasonable, other occupants a G. P. and a dentist. Phone 482-9440 area 517.

MEDICAL DIRECTOR—Single County Health Department; population approximately 165,000. Department has 40 full time employees. V.D., T.B., and general health programs being followed. Good relations with local physicians. Excellent recreational and school facilities available. If under age 50, M.D., M.P.H. required. Over 50, 9 weeks of special training required within 3 years in lieu of M.P.H. Salary range $23,000 to $27,500, depending on qualifications and experience. Many fringe benefits. Send resume to James V. Wells, Chairman, Muskegon County Board of Health, County Building, Muskegon, Michigan 49440.

GENERAL PRACTITIONER, with surgical experience desires to relocate in Michigan, leading to possible permanent association. Age 55, good health, married, Michigan license. Reply 2733 E. Newton Ave., Milwaukee, Wisc. 53211.

17 BED HOSPITAL FOR SALE in East Grand Rapids. Has functioned for years as Burleson Hospital, diseases of the rectum. Available due to death of principal. Favorable terms. Ideal for use as is or possible conversion. Furniture and equipment included. Separate brick office building with small apartment over. Excellent location near Blodgett Hospital and Ramona Medical Center. Contact Mr. Tyson evenings—616-243-7777 or Ben M. Muller Realty Co., Inc., 440 Union Bank Bldg., Grand Rapids (616) 456-7114.

PSYCHIATRIC RESIDENCIES: Starting July 1969. Approved training in a mental institution with State of Michigan, Department of Mental Health. There are five year programs available. Salary $9,876-$11,233 and $11,254-$21,381. NIMH-GP stipends $12,000. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. For additional information, contact Dr. Paul Kauffman, Training Director, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

RADIOLOGIST, INDIANA, V.A.—Salary $20,000 to $23,000. Liberal fringe benefits. Write or call Chief of Staff, Veterans Hospital, 1600 Randalia Drive, Fort Wayne, Indiana 46805. An Equal Opportunity Employer.

WANTED: Two general practitioners to join two general practitioners in a large well-established practice of over 30 years in a town with population of 800 and covers large rural area of approximately 5,000. Location is 50 miles north of Minneapolis, Minn. in excellent hunting and fishing area with golf, bowling and other recreation also available. Have local community hospital, Medicare approved and equipped for general medicine and major and minor surgery. Salary negotiable, partnership available. New clinic planned. For references contact Dr. Gerald Larson, Cambridge Minnesota, Dr. Joe Halpin, Rush City, Minnesota; Dr. Richard Varco, Dept. of Surgery University of Minn. Medical School, Minneapolis, Minnesota; Dr. Dean Rizer Internist, Medical Arts Bldg., Minneapolis, Minnesota; Dr. Paul Larson, OB-Gyn, Medical Arts Building, Minneapolis, Minnesota. If interested send application and references to Braham Clinic, Attn: Wm. T. Nygren, M.D., Braham, Minnesota 55006, or phone area code 612-396-3355 between hours of 10-12 A.M. or 1-5 P.M. Monday thru Friday. If after hours phone 612-396-2153. May call collect. If acceptable, expenses for personal interview will be allowed.

BOARD ELIGIBLE or qualified orthopedist to be associated in group practice of industrial surgery and medicine. Wide field of private orthopedic practice open. 205 Medical Arts Center, Muskegon, Michigan 49440. Telephone (616) 722-2606.

University Health Service: State University in Central Michigan seeking competent physician to complete staff. Present staff congenial. Pleasant working conditions. New facility to open in fall. Easily accessible to cultural and recreational center of Michigan. 12 Months contract with excellent fringe benefits. Salary competetive. Russell Ragan, M.D., Director Student Health Service, Central Michigan University, Mt. Pleasant, Michigan 48858.

These Advertisers Help Make Michigan Medicine Possible

Brighton Hospital 78
Brown Pharmaceuticals 76
Burroughs-Wellcome 63
Campbell Soup Co. 15
Classified Advertising 83
Geigy Pharmaceuticals 26, 27, 28, 66
Gerber Products 23
Glenbrook Lab. 51
Hynson, Westcott & Dunnings, Inc. ..... Cover II
Ingram, G. A. & Co. 70, 76
Lederle Laboratories 6, 13, 14, 71
Lilly, Eli & Co. 30
Michigan Medical Service 8
Medical Protective 78
Mediclinics 29
Mercywood Hospital 83
Parke-Davis & Co. 19
Pitman-Moore Div., Dow Chemical Co. 68, 69
Plainwell Sanitarium 52
Poythress, Wm. P. & Co. 67
Professional Management 52
Purdue Frederick Company 77
Robins, A. H. & Co. 18, 29
Roche Laboratories ..... 64, 65, Cover IV
Roselawn Manor 70
Searle, G. D. & Co. 16, 17
Stratton, Ben P. ..... Cover III
Winthrop Labs 20
Wyeth 10, 11, 53, 54, 81

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road **Conducted by Sisters of Mercy** **Ann Arbor, Michigan**

Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

Lyle M. Allis, M.D.
Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.*
Sydney Joseph, M.D.
Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Richard D. Watkins, M.D.
Stephen C. Mason, M.D.
Philip M. Margolis, M.D.
Hubert Miller, M.D.

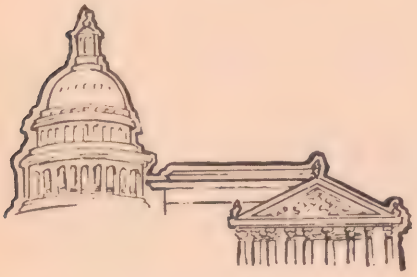
* 1904 - 1967

NOTES & QUOTES

BY HERB AUER

"All federal legislation affecting urban affairs should be brought together under one roof rather than continue the present conditions where eight standing committees of the House of Representatives have jurisdiction over urban programs."

That proposal is being advanced in Washington by James Harvey, U.S. Congressman from Saginaw who has been enthusiastically supported by Michigan physicians. In urging greater emphasis on the problems faced by cities, Representative Harvey has



advocated block grants by the Federal Government to states in contrast to the categorical grants-in-aid.

* * *

Though Wilbur Cohen will formally rejoin the University of Michigan upon his departure from the HEW secretaryship, he reportedly will "spend a good deal of his time helping Congressional Democrats continue the fight for the Great Society," according to Monroe W. Karmin, Wall Street Journal legislative expert. Mr. Cohen now is proposing that Medicare be expanded to cover the cost of drugs and to make the program available to disabled persons and infants.

Harvard Professor John Dunlop was appointed soon after the November election by President-Elect Nixon to head a special task force to develop a Nixon Administration health program.

* * *

George Klutke, M.D., Dearborn, was a busy doctor November 26 at Dearborn's Oakwood Hospital when he delivered quadruplets to Mr. and Mrs. Gustave Pulter — the first set of quads in the Detroit area in eight years. The three daughters and one son were six weeks early.

* * *

More than once the MSMS Aging Committee has recommended that every component county medical society have an Aging Committee.

One fact alone explains dramatically why such a committee is important — "Of all human beings who have reached the age of 65 since the dawn of recorded history, 25 per cent of them are alive today."

The AMA Committee on Aging, with Frederick Swartz, M.D., Lansing, continuing as the chairman, has three major goals that a county society also could adopt: (1) to promote positive health and meaningful living among the older persons; (2) to encourage long-range preventive efforts for the smaller segment of the older group who are frail or fragile; and (3) to help attain the best possible health care and maximum restoration for those who are ill.

* * *

The surgeon who performed the knee operation on Notre Dame's famed Terry Hanratty this fall was Leslie Bodnar, M.D., team physician, who spoke about knee injuries at the 1968 MSMS Conference on Medical Aspects of High School Sports.

* * *

Had you noticed that every scientific article in this issue can be easily pulled out and filed without disturbing any other article? Every scientific article begins on a right-hand page . . . as they did in the December issue. This new feature will make **Michigan Medicine** even more valuable as a continuing medical education tool.

* * *

Many of the duties of producing the MSMS journal are now being assumed by Judy Marr, who joined the MSMS staff December 1. Mrs. Marr, a MSU journalism graduate, had been employed as



a reporter at the Lansing State Journal for the past three years.

* * *

The suggestion that the public would benefit if pharmacists furnished doctors with lists comparing wholesale prices of branded and generic products was made by Senator Hart at a meeting of the Muskegon County Medical Society. "Then a doctor could place his order in the way any good purchasing agent would — balancing anticipated performance against cost." This proposal, he said, would encourage price competition among the pharmaceutical firms.

* * *

The cover this month helps call attention to the Seventh Annual Michigan Conference on Maternal and Perinatal Welfare, which MSMS will sponsor March 26-27 at the Pick-Durant Hotel in Flint. Interested MSMS members, interns, residents, students, nurses may obtain a program by writing MSMS, Box 152, East Lansing. See Page 4 for highlights.

YOUR DISABILITY INCOME PLAN IS NOW A BETTER BUY THAN EVER!

INCREASED INDEMNITY

You can now purchase a monthly benefit of up to $1,000. (The former limit was $500.) If you also have additional coverage, Provident will participate in total coverage providing up to $2,500 a month in benefits. These limits are subject to 55 percent of earnings. And remember, your disability income benefit is tax free.

CONVERSION GUARANTEE

You have a conversion guarantee in case the plan is terminated or in case you move your practice outside Michigan. You can convert to an individual policy, providing exactly the same coverage and benefit, and guaranteed continuable to age 70.

EXTENDED BENEFITS

If you are currently insured and your sickness benefits are payable to age 65, your sickness benefit is automatically extended to lifetime payments for sickness disability beginning prior to age 50.

ABBREVIATED MONTHLY BENEFIT AND ANNUAL PREMIUM SCHEDULE

Attained Age on Effective Date & Renewal Ins.	Monthly Indemnity	Lifetime Accident 5 Years Sickness (L-5 Plan)	Lifetime Accident Sickness to Age 65 (L-65 Plan)
Thru 33	$500	$ 63.50	$ 88.50
Cost for each additional Monthly Indemnity	$100	11.90	16.90
34 - 49	500	151.70	201.70
Cost for each additional Monthly Indemnity	$100	28.70	38.70
50 - 65	500	214.60	264.60
Cost for each additional Monthly Indemnity	$100	41.20	51.20
60 - 65	500	214.60	214.60*
Cost for each additional Monthly Indemnity	$100	41.20	41.20*

* Renewal Only

Semi-annual premiums are one-half the amounts shown above

BEN P. STRATTON AGENCY, INC.
MSMS Insurance Administrators
P. O. Box 547, Lansing, Michigan 48903
Telephone: (517) 484-2578

MJ
NATL LIBR OF MEDICINE
8600 WISCONSIN AVE
BETHESDA 14 MD 20014

Whenever anxiety induces or intensifies clinical symptoms

Librium®

(chlordiazepoxide HCl)

Quickly relieves anxiety~Helps improve response in psychophysiologic disorders~Seldom impairs mental acuity or physical coordination,on proper dosage~Has wide margin of safety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE

Roche®

LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Also available: ***Libritabs***™ *(chlordiazepoxide) 5-mg, 10-mg, 25-mg tablets*

WI
MI 223
R

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

JANUARY, 1969 • VOLUME 68 • NUMBER 2

FEB 1969

MSMS For Many Legislative Programs

BY M. A. RILEY
MSMS LEGISLATIVE COUNSEL

The Michigan State Medical Society will urge the 1969 Michigan State Legislature to enact new laws to regulate the practice of hypnosis, to permit minors to give their own consent to venereal disease examination and treatment, to repeal Michigan's obsolete Basic Science Law, and to make a number of improvements in the statutes dealing with malpractice. Several of these proposed laws were recommended by the MSMS House of Delegates in September, 1968 and others have been developed by the MSMS Legal Affairs Committee and approved by the Society's Council.

VD

The House of Delegates directed that an attempt be made to amend Michigan's laws so that a person under 21 years of age could give his own consent for examination for, and treatment of, venereal disease. Similar laws have recently been enacted by California and New Jersey. Although the treating physician would not be *required* to obtain parental consent, he would have the discretion to notify the parent or another responsible adult if he chose. State Representative Mrs. Lucille McCullough, of Dearborn, will introduce such a proposal with MSMS endorsement.

Hypnosis

After an exhaustive study of implications and recommendations from a number of authoritative sources, the Legal Affairs Committee recommended, and The Council endorsed, introduction of a bill in 1969 to regulate the teaching and practice of hypnosis. Based on a recent New York statute, the new Michigan law would restrict the inducing of hypnosis to licensed doctors of medicine, doctors of osteopathy, or doctors of dentistry. Hypnosis could only be taught in legitimate educational institutions or properly approved hospitals, or in courses authorized by medicine, osteopathy or dentistry. Public exhibitions of hypnosis would be rigidly controlled. MSMS feels that such legislation will be particularly helpful in Michigan's metropolitan areas.

Basic Science

Once again the Michigan State Medical Society will ask the State Legislature to completely repeal the 1939 Basic Science Law, long considered obsolete by our State's medical educators. A bill to accomplish such a repeal was passed a few years ago by the State Senate; the following year the bill was passed unanimously by the State House of Representatives; in 1967 the bill was again passed by the Senate but failed in 1968 in the House. Repeal has been endorsed by the Michigan Department of Licensing and Regulation on the grounds that the Basic Science examinations, which now affect only doctors of medicine, doctors of osteopathy and chiropractors, are duplicative and unnecessary. MSMS has long maintained that this examination creates a major barrier to the attraction of needed physicians to serve the people of Michigan.

Malpractice

Following the recent lead of the State of California, MSMS will seek in 1969 to gain legislative approval for several new statutes dealing with court malpractice actions. One of these, now the law in California, would specifically state that the statute of limitations on a malpractice case commences to run from the date of the act, unless there has been fraud or intentional concealment. At the moment Michigan law is extremely hazy as to precisely when the statute of limitations does commence to run.

A second proposed new law would provide for a separate trial, in advance of the malpractice action, on the question of whether

Plane-to-Spain Adds Openings
SEE PAGE 87



MSMS Legal Affairs Committee, led by MSMS Secretary Kenneth Johnson, M.D., in absence of Chairman Otto K. Engelke, M.D., meets with executive secretary and legal counsel of Michigan State Pharmaceutical Association to discuss 1969 pending legislation.

or not the statute of limitations had or had not run out. At present, in a malpractice case, the case itself and the statute of limitations are usually under consideration simultaneously; after a considerable period of time on the part of the court, plaintiffs and defendants, it may be found that the case, under the statute of limitations, should be thrown out. MSMS' bill would settle this issue first, obviously a good thing for all concerned.

Third, as requested by the MSMS House of Delegates in 1968, a bill will be introduced to extend the protection from liability now granted by Michigan law to in-hospital staff committees, seeking to reduce morbidity or mortality or to advance medical research and education, to similarly engaged committees of MSMS, county medical societies, or medical specialty societies. Such a statute would simply expand coverage already granted by the Michigan Legislature in passing Act 270 of 1967 and vastly assist the medical profession in the business of carrying out internal professional review and discipline by protecting from capricious law suits those who must review the performance of their fellows.

Finally, the House of Delegates has asked that a bill be introduced requiring the claimant to file a $500 bond in a malpractice action, which would be awarded to the defendant physician for defense costs if he were found blameless. Such a statute would do much to prevent baseless suits against physicians, many of which are filed for the sole purpose of obtaining rewards in out-of-court settlements. While the courts now have discretion to require such a bond, it is felt that the requirement should be made mandatory, so as to eliminate a large volume of nuisance claims annually plaguing the courts and taking valuable time badly needed by busy physicians.

Other "Positive" Positions Taken

These seven bills constitute only a part of MSMS' *positive* legislative program for 1969 — things the Michigan State Medical Society *favors*. In addition, the 1968 House of Delegates has directed that the Society support a change in the present abortion laws of Michigan which would remove jurisdiction of the criminal code of Michigan from all abortions performed by licensed medical and osteopathic physicians in accredited hospitals licensed by the State of Michigan. MSMS, while it will have some technical amendments to suggest, supports the adoption by the Michigan Legislature of an anatomical gift act which will have uniformity with other States of the nation.

The Society has also adopted a very positive stance in adopting a policy to *oppose* "any legislation which would degrade the profession and dignity of a registered nurse or in any way equate the status of a registered nurse with persons of less training."

MSMS' House of Delegates has also directed that encouragement be given to the enactment, by the 1969 State Legislature, of laws which will more strictly enforce existing laws relative to driving while drunk and impose more severe penalties for violations, better detect and prosecute reckless and careless drivers, and provide for a more careful and appropriate interval examination for all drivers.

Further Studies Underway

A number of MSMS committees are hard at work in areas which may lead to future progressive legislative requests. Among these are a study of the advisability of requiring by State law that all salt for table use be iodized, a continuing study of the potential of a state-wide medical examiner system and the creation of completely revised medico-legal investigative machinery, and an examination into the advisability of granting a State license to "medical technologists." A separate "blue ribbon" committee, with membership representing general practice, specialty groups and several MSMS committees is undertaking a comprehensive study of the availability of hospital privileges to all ethical licensed physicians. MSMS has expressed its policy that *all* such doctors should have staff privileges in *at least* one full facility hospital in their geographical area of practice.

UP, UP AND AWAY TO SPAIN

Second Contingent Scheduled To Meet Overflow Demand

The success of the American Association of the Professions—Michigan Association of the Professions "Plane to Spain" program of February 22 - March 2 is assured. The maximum number that could be accommodated on the first trip was 120 persons and that number has already been reserved.

Additional requests have been received so arrangements have been made for a second trip to be attached to the first one, with departure from Detroit on March 1 returning March 9. The AAP program to be held in Spain will be duplicated for those on this alternate trip. The AAP Inauguratory Session, Reception and Dinner will be held February 22 for the original party and will not be duplicated on March 1. The total charge for the March 1 group will be reduced $9, making the total $350 instead of $359.

In view of the later departure date reservations are being accepted (see application form) until February 1, 1969. Contact the Michigan Association of the Professions, 120 West Saginaw, East Lansing, 48823; or Craven Tours at 202 M.A.C. Avenue, East Lansing, 48823.

Nine Flint Doctors Plan Maternal Meet

The Eighth Annual Michigan Conference on Maternal and Perinatal Welfare is being planned for March 26-27 by a committee of nine doctors. All are of Flint, where the meeting is scheduled.

Heading the committee is Jack W. Thompson, M.D. Members are J. W. Hallitt, M.D.; J. R. Price, M.D.; J. W. Tauscher, M.D.; J. A. Fernandez, M.D.; J. E. Wentworth, M.D.; R. B. Michelson, M.D.; C. A. Brown, M.D., and Gregoire Bolduc, M.D.

Doctor Thompson, a member of the MSMS Maternal Health Committee, was also chairman of the 1968 Maternal and Perinatal Welfare Conference.

PPLICATION FORM — detach and mail to:
RAVEN TOURS, INC.
02 M.A.C. Avenue
ast Lansing, Michigan 48823
el: (517) 351-9210

ake checks payable to: Michigan Association of the Professions

PS/13

ame_____

ddress_____
(street)

(city, state and zip code)

we wish to PLANE TO SPAIN with the American Association of the Professions and enose a deposit in the amount of $100.00 per person (total deposit enclosed $_____) will be accompanied by: (give full names and relationship of all persons for whom desit is enclosed)

require a single room ☐ (Supplement $35.00)

romise to pay the balance of $250.00 per person not later than February 1, 1969. have read and understand the terms and conditions of the trip, and agree to them.

gned_____ Date_____

U-M Hospital Now Observing Centennial

An extensive calendar of special national and Michigan events has been arranged during 1969 to observe the 100th anniversary of the University of Michigan Hospital.

Harold Falls, M.D., member of the U-M Medical School faculty, will be chairman for the year-long observance. Doctor Falls also is a member of the MSMS Council.

About 5,000 hospital and medical specialists from throughout the United States will attend one or more of the activities during the centennial year. In addition, some 2,000 to 5,000 persons are predicted for the public open house preceding the official opening of C. S. Mott Children's Hospital in the Spring.

Among the organizations which will hold their meetings, conferences, and workshops at University Hospital in conjunction with the centennial are the American Association of Hospital Accountants, the Michigan Hospital Pharmacists Association, the Instrument Society of America, the Michigan Hospital Financial Management Conference, and the national University Hospitals Executive Council.

The Centennial, Doctor Falls reports, is being marked throughout the U-M campus. The Centennial symbol — a script "UMH 100" — has appeared on parking permits, faculty directory, patient guidebook, hospital stationery and postage meters. Uniformed personnel in University Hospital are wearing special blue and white shoulder patches.

The University of Michigan Hospital opened in the late summer of 1869 in a converted faculty residence on the main campus. It was the first University Hospital in the country. It has since grown to a 1,000-bed general hospital which serves as a referral center for medical problems throughout Michigan and the surrounding states.

Heart Association Session Set April 11-12 in Detroit

The Michigan Heart Associations 20th annual Scientific Sessions for Physicians, scheduled April 11 and 12 at the Sheraton-Cadillac Hotel, Detroit, will deal with three aspects of cardiac therapy — coronary care units, coronary artery disease and thromboembolism.

The sessions will be cosponsored by the American Heart Associations Council on Clinical Cardiology. Among the out-of-state speakers will be:

James K. Alexander, M.D., director, Cardiovascular Research Laboratories, Baylor College of Medicine, Houston.

Leonard Dreifus, M.D., director, electrocardiographic unit, Hahneman Medical College, Philadelphia.

Albert A. Kattus, M.D., visiting professor of experimental medicine, Vanderbilt Hospital, Nashville.

Thomas Killip, III, M.D., professor of internal medicine, Cornell University Medical Center.

Bruce Logue, M.D., chief of cardiology, Emory University, Atlanta.

Henry Wagner, Jr., M.D., professor of radiological science, Johns Hopkins Medical Institutions, Baltimore.

Former Doctor of Year, G. P. Raynale, Dies

George P. Raynale, M.D., Birmingham, former chief of staff of St. Joseph Hospital, Pontiac, died Dec. 22 at the age of 88.

Doctor Raynale, who was honored as Michigan's "Doctor of the Year" in 1961, retired in 1966 after practicing for 64 years. A native of Birmingham, he was a 1902 graduate of the Detroit College of Medicine, did postgraduate work at Guys' Hospital in London, England, and served as a field surgeon in France during World War I.

Doctor Raynale, a third-generation physician, specialized in surgery and was a Fellow of the American College of Surgeons. He had also been affiliated with William Beaumont Hospital in Royal Oak.

ADD: IN MEMORIAM

Charles F. Wible, M.D., 46, Sebewaing, died Dec. 4.

Michael J. Medvezky, M.D., 61, Bay City, died Dec. 6.

Albert R. Dickson, M.D., 80, Battle Creek, died Dec. 5.

George C. Burr, M.D., 78, Grosse Pointe, died Dec. 10.

David P. Philips, M.D., 76, Lansing, died Dec. 14.

Robert E. DeLong, M.D., 47, Kalamazoo, died Dec. 7.

Two Doctors Among Presidential Electors

When Michigan's presidential electors met to cast their ballots, two MSMS members were among them. They were Alfred Sokolowski, M.D., Republican elector from Detroit, and Bernard O'Hora, M.D., Democratic elector from Midland.

Doctor Marshall Leads MARMP

Don Marshall, M.D., of Kalamazoo, is new president of the Michigan Association of Regional Medical Plans (MARMP).

Doctor Marshall, former vice-president, succeeds William N. Hubbard, Jr., M.D., dean of the University of Michigan School of Medicine.

Other new officers are Ernest Gardner, M.D., dean of the Wayne State Medical School, vice-president, and Dorothy Carnegie, D.O., Lansing, secretary-treasurer.

Those elected to the Board of Directors are John Gronvall, M.D., University of Michigan; John Peirce, M.D., coordinator of medical education at St. Mary's Hospital, Grand Rapids; Gerald Rice, M.D., Lansing, director of the Michigan Department of Public Health; Eugene Sibery, Detroit, executive director of the Greater Detroit Area Hospital Council; Ronald Yaw, Grand Rapids, director of Blodgett Memorial Hospital, and Doctor Hubbard.

Second Class Postage Paid at Lansing, Mich.

Michigan Medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at Lansing, Michigan. Yearly subscription rate, $9.00. Printed in USA. All communications should be addressed to Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.
© 1969 Michigan State Medical Society.
Phone: Area Code 517, 337-1351.

MJ
NATL LIBR OF MEDICINE
8600 WISCONSIN AVE
BETHESDA 14 MD 20014



W1
M I 4 2 3

RECEIVED
FEB 2 3 1969
National Library

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

FEBRUARY, 1969 • VOLUME 68 • NUMBER 3

INSIDE FEATURES:

Doctors Attack Drug Abuse
Future of Private Practice
Grand Rapids' Emergency Medical Care

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

■ LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.

■ Literature on indications and dosage available on request.

■ No side effects have been reported, even when massive doses (25 tablets per day) were administered.

■ Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

FEBRUARY, 1969 • VOLUME 68 • NUMBER 3

Governor Backs 4-Year MSU Medical School In 1969 Budget Recommendations

BY M. A. RILEY, MSMS LEGISLATIVE COUNSEL

The Milliken-Romney 1969-1970 budget, released to the State Legislature on January 22, recommends that Michigan State University proceed with planning for a four-year medical school, and provides funds for this purpose.

The budget message reads, "The present and increasing need for more physicians dictates that this expansion now be authorized and developed."

Glenn Allen, State Budget Director, said that the recommendation regarding MSU's proposed four-year medical school means that the Governor has given it "the green light" and that he is very favorable.

ADDITIONAL FUNDS HAVE been recommended for both capital construction and accrual of faculty at Wayne State University Medical School, as a part of an on-going program of development leading to a doubling of that institution's present number of physician graduates.

WSU, which now produces about 130 physicians each year, plans to accept over 250 students annually by the Fall of 1971.

The Executive budget also contains one and one-half million dollars for continuation of construction of a "Life Sciences" building as a part of the present two-year MSU medical school, and an additional $1,000,000 for the renovation of the University Hospital at the University of Michigan.

The Michigan State Medical Society has long urged that the medical education facilities at the University of Michigan, Wayne State University and Michigan State University be brought to full function with all possible speed. In September of 1968 MSMS' House of Delegates, for the third successive year, called for action to boost MSU to a degree-granting status.

THIS YEAR MSU HAD placed expansion of its medical college from a two to a four-year institution as the top priority item in the school's 1969-1970 budget request.

MSMS, in early November of 1968, also supported the concept of Michigan's medical schools offering their students curricula which would make possible the granting of either the degree of Doctor of Medicine or Doctor of Osteopathy. Early in December of 1968 it was reported that the Deans of all three schools had agreed to consider such a program in their respective institutions.

The Governor's 1969-1970 budget message, in recommending the MSU 4-year medical school, states, "Every effort should be made to encourage the two established medical schools and the new school at Michigan State to provide training options for both allopathic and osteopathic professions."

After Governor Milliken presented his budget, State Board of Education President Edwin L. Novak offered a number of observations. In part, he said:

"The Governor also has asked that Michigan State University's medical school move toward a full, four-year program in an effort to meet the state's worsening shortage of physicians. This is a crisis which the State Board has also recognized and previously made recommendations in line with those of the Governor."

See Index On Page 95 for February Articles



MSMS Secretary Kenneth Johnson, M.D., briefs Michigan State University medical students on legal issues. The students, guests at a recent meeting of the MSMS Legal Affairs Committee, are, left to right, Heront Marcarian, Ron Tokar, MSU Student American Medical Association president, and Rodney Justin.

MED SCHOOL DEANS WILL CONSIDER OPTIONAL DEGREES

The deans of Michigan's three medical colleges have agreed to consider establishment of optional degree programs in doctor of medicine and doctor of osteopathy in their respective institutions.

In a letter to Dr. Ira Polley, state superintendent of public instruction, the deans of Wayne State, University of Michigan and Michigan State University medical schools said they had met recently and reached agreement that it "is feasible" to offer the optional degrees within their school programs.

The letter, signed by William M. Hubbard, Jr., M.D., dean of the U. of M. Medical School, said the three deans are looking forward to further meetings to review how such a program would be carried out, as well as discussions with appropriate licensing agencies and with national accrediting agencies.

MEDICENTERS TO BUILD FACILITY

Medicenters (whose board chairman is president of the Holiday Inns chain) will erect a $2.6 million extended care facility adjacent to Providence Hospital in Detroit.

Construction will begin in Spring for the 248-bed recuperative care facility. Sister Irene, hospital administrator, reports cost will be at least 50 percent less than a stay in the hospital.

Medicenters will operate the facility.

U-M Public Health School To Expand Enrollment

The U-M School of Public Health will expand its enrollment from the current 429 to 525 by 1972 after completion of a new seven-story building. The building, which will consolidate units now in 13 separate locations, is being financed by U-M funds, $2 million from the W. K. Kellogg Foundation and $5 million from the federal government.

HYPERTENSION SYMPOSIUM SET IN LANSING

The second annual Hypertension Symposium will be presented by the Hypertension Clinic of Edward W. Sparrow Hospital in Lansing and Michigan State University College of Human Medicine, March 12 and 13, at the Kellogg Center in East Lansing.

The first day will feature Dr. Harriet Dustan of the Cleveland Clinic and Dr. Roger Hickler from Harvard Medical School, who will discuss the principles of therapy and evaluation of the patient with hypertension. An interesting evening program and several elective opportunities will be offered.

For further information contact the Program Director, R. M. Daugherty, Jr., M.D., 120 Giltner Hall, Michigan State University, College of Human Medicine, East Lansing.

Freitas, Teed Join Judicial Commission

The official tabulation of the ballots for the MSMS Judicial Commission election revealed the following men had been elected to serve on the important MSMS group during 1969.

Donald N. Sweeny, Jr., M.D., Detroit, chairman of the commission last year, and Harold A. Furlong, M.D., Pontiac, last year's vice chairman, were re-elected.

New commission members are Eugene L. Freitas, M.D., Detroit, and R. Wallace Teed, M.D., Ann Arbor.

Doctor Freitas and Doctor Sweeny represent District One, which is Wayne County, while Doctor Furlong represents District Two (Macomb, Oakland, St. Clair Counties) and Doctor Teed represents District Three (Ingham, Livingston, Monroe, Washtenaw and Shiawassee Counties).

The Judicial Commission, according to the MSMS Constitution, "Shall be the body having general jurisdiction in matters relating to professional ethics, grievances, mediation, discipline of members and professional conduct generally."

Wayne Unit Paces TB Seal Sale

The Michigan Tuberculosis and Respiratory Disease Association's Wayne County branch, headed by E. Osborne Coats, M.D., is one of the leaders in the recent Christmas Seal sale.

As of Jan. 3, the Wayne association had raised $364,791 compared with $358,943 at that time last year. Other county leaders are Oakland and Macomb.

The state-wide drive was 2.3 percent ahead of last year's on Jan. 3 and had gathered in 89 percent of its goal, according to Winthrop N. Davey, M.D., Ann Arbor, state president. The total earnings were $1,381,257, up $31,307 from last year's amount.

Lansing Doctor Helps Organize Emergency MDs

A Michigan physician has been a moving force in the formation of the American College of Emergency Physicians.

John G. Wiegenstein, M.D., Lansing, will preside as president of the ACEP at its organizational meeting February 7-8 at the Palmer House in Chicago.

The national society for the growing number of hospital emergency-service physicians was organized this fall by Doctor Wiegenstein and a group of interested doctors from various states. Active membership is open to "physicians who voluntarily devote a significant portion of their medical practice to emergency medicine and surgery."

At the Chicago conference, organizational matters will dominate, along with educational addresses. National leaders in the field of emergency care will discuss education, research, etc. AMA and HEW officials will discuss community emergency services.

The ACEP has adopted eight objectives which will seek "to advance the ethical standards of the private practice of emergency medicine and surgery," "to improve emergency services rendered the patient," along with other goals to encourage training, coordination, etc.

NEW BLUE CROSS I.D. CARDS OUT

Michigan Blue Cross-Blue Shield has issued new plastic identification cards designating holders as eligible for Blue Cross-Blue Shield coverage and providing information regarding their benefits and enrollment status.

The new cards were distributed in December and contain a revised coding for benefits which are part of a new automated system being used by Blue Cross-Blue Shield.



James Harryman, M.D., left, chairman of the MSMS Maternal Health Committee, and Jack Thompson, M.D., Flint, discuss plans for the Eighth Annual Maternal and Perinatal Welfare Conference in Flint March 26-27. Doctor Thompson is chairman of the conference.

Doctor Guttmacher To Lead Maternal Welfare Conference in March

Six out-of-state speakers, with Alan F. Guttmacher, M.D., of New York City, most noted among them, will appear at the Eighth Annual Michigan Conference on Maternal and Perinatal Welfare March 26-27 in Flint.

Doctor Guttmacher is president of Planned Parenthood-World Population of New York City and is the author of several well-known books on pregnancy and childbirth. He is licensed with the American Board of Pathology and has been on the faculty of the Albert Einstein College of Medicine, Yeshiva University, New York City.

The conference committee, headed by Jack W. Thompson, M.D., also emphasizes the appearance of Bradley E. Smith, M.D., associate professor, department of anesthesiology, the University of Miami, whose talk, the last scheduled in the conference, will have wide appeal.

Doctor Smith, who is affiliated with Jackson Memorial Hospital in Miami, will discuss drugs, in relation to anesthesias, used just before and during Labor, that may have considerable effect on the baby.

"Doctor Smith's talk should be of interest to pediatricians, obstetricians and general practitioners alike," notes Doctor Thompson.

The only woman scheduled to speak is Murdina M. Desmond, M.D., of Houston. She is a professor of pediatrics at Baylor University School of Medicine and will speak on the "Neurological Evaluation of the Newborn."

Other out-of-state speakers are; Herbert S. Kupperman, M.D., Ph.D., associate professor of medicine, department of therapeutics, New York University Medical Center; John W. Huffman, M.D., Children's Memorial Hospital, Chicago, and John W. Goldzieher, M.D., San Antonio.

Doctor Kupperman is a general practitioner specializing in obstetrics and gynecology and is affiliated with the New York University School of Medicine, New York City. Doctor Huffman is also a general practitioner specializing in obstetrics and gynecology. Doctor Goldzieher is a full-time general practitioner specializing in internal medicine.

Health Council's New Officers Announced

E. Gifford Upjohn, M.D., assumed the presidency of the Michigan Health Council at its recent annual meeting at Northwood Institute, Midland. Doctor Upjohn, chairman of the board of The Upjohn Company, Kalamazoo, member of the board of Borgess Hospital, Kalamazoo, and an active member of the University of Michigan Medical School alumni organization, succeeds Harry A. Towsley, M.D., of Ann Arbor. Doctor Upjohn's main work is in pharmaceutical research, particularly in the area of diabetes.

F. D. Ostrander, D.D.S., Ann Arbor, professor of dentistry at the University of Michigan, past-president of the American Dental Association and the Michigan Dental Association, was named president-elect.

Re-elected secretary of the group was Hugh W. Brenneman, East Lansing, executive director of MSMS and executive director of the Michigan Association of the Professions.

Elected to the board of trustees for three-year terms were Richard U. Byerrum, Ph.D., dean of the College of Natural Science, Michigan State University; Sidney E. Chapin, M.D., medical director, home care program, Detroit V.N.A.; Andrew Patullo, Battle Creek, director, division of hospitals, W. K. Kellogg Foundation; S. D. Steiner, M.D., Detroit, medical director, General Motors Corp.; E. A. Irvin, M.D., Detroit, medical director, Ford Motor Co.; Herbert Estes, Ann Arbor, member of the board of trustees of Alma College, and William Henessy, Grosse Pointe, president-elect of the American Pharmaceutical Association and past president of the Michigan State Pharmaceutical Association.

Other officers are John C. McCabe, Detroit, president of Michigan Medical Service, treasurer; John A. Doherty, East Lansing, executive Director, Michigan Health Council, assistant treasurer; Robert E. Rice, Greenville, chairman of the MHC M.D. Placement Service, medical advisor and Marvin L. Niehuss, former executive vice president, University of Michigan, legal counsel.

The council representatives approved the membership of four new voting members, Mercy College, Detroit; North Central Michigan College, Petoskey; Care, Inc., and Hillsdale College.

They also approved the organization's largest budget in its 25 year history, for more than a total of $100,000.

Coming to Speak At Heart Session

Among the outstanding speakers scheduled for the Michigan Heart Association's 20th Annual Scientific Sessions for Physicians April 11-12 in Detroit, is James K. Alexander, M.D. Doctor Alexander is professor of medicine, head of the cardiac section of the Department of Medicine and director of the Cardiovascular Research Laboratory of Baylor University College of Medicine. He is also head of the Cardiac Department of Ben Taub General Hospital in Houston. Doctor Alexander is currently program director of the Postdoctoral Medical Training Program in Cardiovascular Disease and the Undergraduate Training Program in Cardiology at Baylor.



DR. ALEXANDER

Clinical Society Schedules Dr. Steiner on 'Proinsulin'

"Proinsulin: Current Concepts" will be discussed by Donald F. Steiner, M.D., professor of biochemistry, University of Chicago, before the Clinical Society of the Michigan Diabetes Association March 5.

The group will meet for dinner at 6:30 p.m. at Stouffer's Northland Restaurant in Southfield.

Cancer Foundation Led by Doctors

Michigan doctors will lead the Michigan Cancer Foundation during the coming year.

Brock E. Brush, M.D., Dearborn, continues as chairman of the board, while Michael J. Brennan, M.D., Detroit, is president of the foundation.

Other doctors at the helm include Rosser L. Mainwaring, M.D., Dearborn, vice chairman of the board, William L. Simpson, M.D., Detroit, executive vice president; Gerald S. Wilson, M.D., Lathrop Village, secretary; Joan Stryker, M.D., president of the Downriver Unit; John J. Kelly, M.D., Downriver Unit representative, and Charles L. Schneider, M.D., Dearborn, vice president of the Western Wayne County Unit.

ILLNESSES OF VIETNAM WAR TO BE DISCUSSED

"Diseases of the Returning Vietnam Veteran" is the theme of a meeting for all interested Michigan doctors scheduled from 4:30 to 9:30 p.m. Feb. 6 at Edward W. Sparrow Hospital, Lansing.

The seminar will be jointly sponsored by Sparrow Hospital and Michigan State University's College of Human Medicine and Continuing Education office.

Norman McCullough, M.D., Michigan State University, will discuss "Arbor-borne Viruses," including chikungunya, dungue-fever, encephalitis, scrub-typhus, hemorrhagic fever and also venereal disease, diarrhea, leptospirosis, parasites and plague.

Other speakers include Marion H. Brooks, M.D., Northwestern University, whose topic is "Malaria," and Rodney Bentz, M.D., The University of Michigan, who will talk about "Melioidosis." A Michigan Department of Health representative will describe aid his department may give doctors treating such diseases.

Interested doctors may make reservations with Bruce W. Alderman, 55 Kellogg Center, Michigan State University.



JAMES J. LIGHTBODY, M.D.
PRESIDENT, 1968-69

Any Federal Takeover Would Raise Costs More

We received a lengthy telegram dated December 31st from one Wilbur J. Cohen who stated that: "Physician's fees are likely to increase substantially in 1969 and 1970 over current levels" and he asked for restraint on both fees and utilization on the part of the medical profession of Michigan.

Mr. Cohen also indicated in the telegram that the present individual monthly rate of $8.00 for the supplementary medical insurance program of Medicare would be maintained at least to June 30, 1970 to make sure that the Medicare program would have limits of liability – even if the cost of medical service continued to rise.

Section 1801 of the Medicare Law states: "Nothing in this Title shall be construed to authorize any Federal officer or employee to exercise any supervision or control of the practice of medicine or the manner in which medical services **are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency or person providing health service.**"

OBVIOUSLY MR. COHEN believes that to control costs of medical care there must be complete control over hospitals, physicians and all personnel associated with the distribution of this care.

He has proven in testimony before the Senate Committee that he had planned to push ahead for "Group Practice," which to him means consumer or hospital controlled, prepaid, comprehensive care with no fee-for-service principle involved. Mr. Cohen has claimed that Government administration and supervision over hospitals and doctors' practices would cure inefficiencies and lower costs.

Has anyone ever heard of any project that the government took over that lowered costs?

Any takeover of the practice of medicine by political, socialistic maneuvering by the Secretary of Health, Education and Welfare, and controlled entirely by the consumer, will only lead to deterioration of services and facilities. Senator Magnuson, at a hearing on Health Care costs, called the conglomeration of Federal Health Care programs a "hodge-podge, disorganized, uncoordinated mess" due mainly to the fact that the government is directly in the business of providing health care to its citizens.

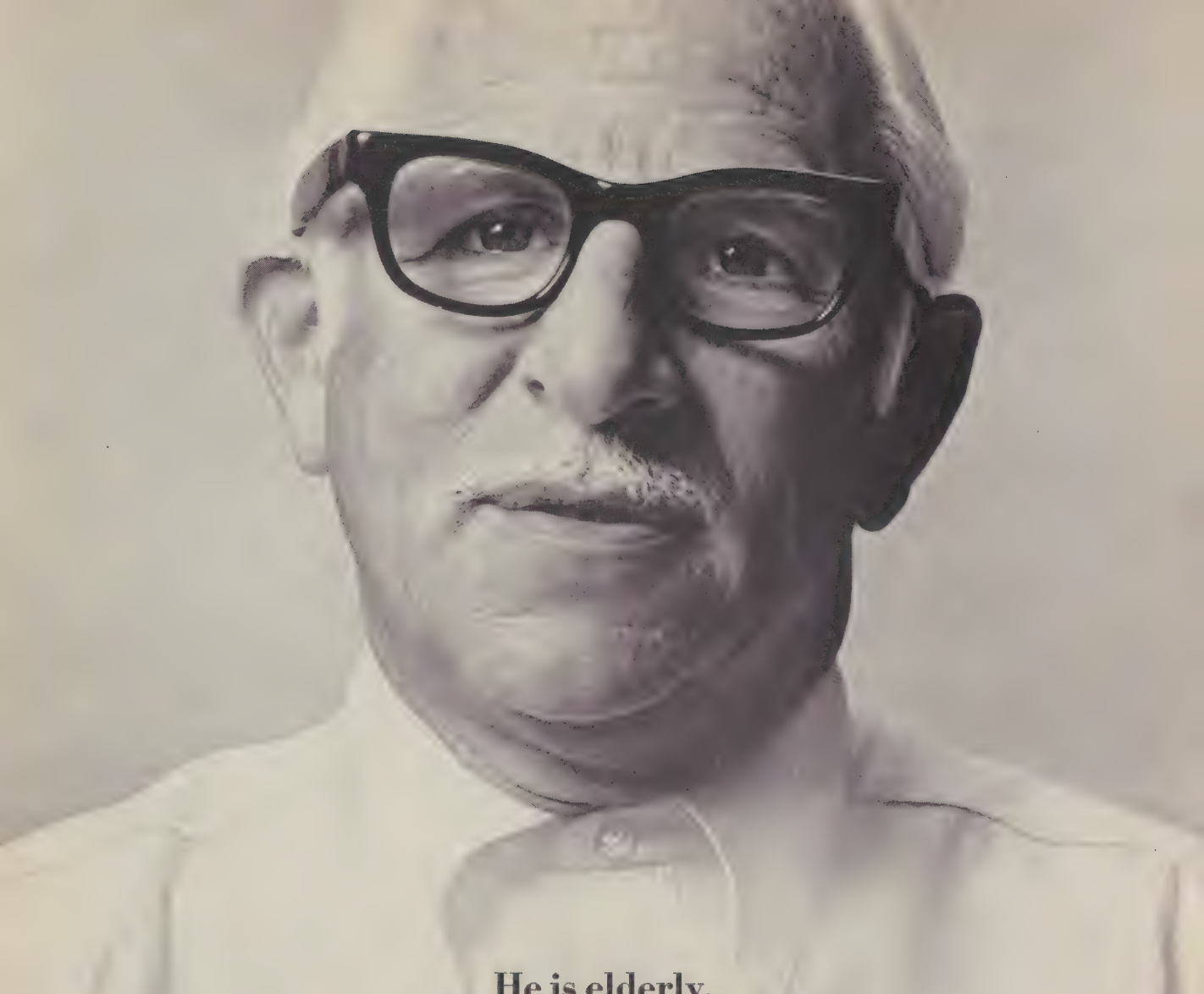
WE AGREE THAT THE costs of medical care are increasing – the reasons are multiple. Some of these are created by the hospitals because of increased salaries for personnel and new equipment and procedures. Other reasons for increased costs may be the demand on the part of patients to be taken care of in hospitals and also the increased demand to stay longer than they should. "Utilization Committees" is not the entire answer to this problem. Individual physicians can help by being their own "Utilization Committee," by telling some patients the facts of life as far as hospital beds are concerned.

Another reason is a serious decrease in the number of endowments to hospitals as this source of funds assisted many hospitals, and another reason is the progressive increase in the general cost of living. Another item is that hospital costs are soaring because of numerous new laboratory procedures which are being ordered and it may be well for each individual physician to analyze what is occasionally labeled as "routine laboratory tests."

THE MEDICAL PROFESSION of Michigan will continue to exercise restraint in both fees and utilization, and with the change of administration in Washington, D.C., on January 20, 1969 Mr. Wilbur Cohen will not be Secretary of Health, Education and Welfare. We hope that he will have more time to consider and readjust his philosophy on health-care and perhaps concentrate his attention on education and welfare.

James J. Lightbody, M.D.





He is elderly, he is on corticosteroids, when he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given the drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company
Pearl River, New York

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by Michigan Medicine. Michigan Medicine will pay the first $25 of the engraving bill, and the authors shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.

6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.

7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

8. Articles should ordinarily be less than four printed pages in length (3000 words).

9. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

10. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

IN THIS ISSUE

SCIENTIFIC ARTICLES

131 **Mouse Toxicity of Triple Vaccine (DTP) Mixed with Poliomyelitis Vaccine; R. Y. Gottshall, G. R. Anderson, E. A. Nelson, K. R. Wilcox, M.D.**

135 **Massive Intra-articular Injection of Methylprednisolone without Harmful Side Effect; J. C. Breneman, M.D.**

SPECIAL ARTICLES

119 **The Future of Private Practice: Salvation at the Grassroots; Lewis A. Miller**

137 **Michigan Physicians Direct Information on Drug Abuse to Youth, Parents; Judith Marr**

140 **Raskin Probes User's Reasons; Calls for Community Drug Control**

142 **Explains 10 Goals of New AMA Division on Public Affairs; Joe D. Miller**

143 **Letter to AMA Evaluates Weaknesses of New Health Laws; Otto K. Engelke, M.D.**

146 **Grand Rapids Leading the Way in Emergency Medical Care Programs**

164 **Chairman of Advisory Comprehensive Planning Council Describes Concepts**

167 **MSMS Council Chairman Urges AMA to Take Leadership on Hong Kong Vaccine Distribution**

172 **Explaining How Michigan Laws Are Made; M. A. Riley**

177 **MVF Benefit Structure Explained; Louis F. Hayes, M.D.**

PHOTO SECTION, Pages 153 to 160 Inclusive

PRESIDENT'S PAGE

93 **Any Federal Takeover Would Raise Costs More; James J. Lightbody, M.D.**

OTHER FEATURES

89 **Breaking News**

100 **Our State Society**

101 **Council Minutes**

104 **Michigan Mediscene**

105 **Auxiliary Events**

129 **Index to 1969 Scientific Articles**

130 **Monthly Surveillance Report**

141 **Socio-Economics**

179 **In Memoriam**

180 **Mailbag**

186 **Notes and Quotes**

Michigan Medicine

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at Lansing, Michigan. Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351.

© 1969 Michigan State Medical Society.



SENOKOT Tablets help place simple, functional constipation in proper perspective. They don't dramatize the problem. They simply help relieve it.

Patients appreciate the gentle ease of laxation that is specific, predictable, comfortable. *Over 95% effective in thousands of reported cases.**

And SENOKOT Tablets won't disrupt the night with peristaltic rushes. Because the action is virtually colon-specific, gently stimulating peristalsis through Auerbach's plexus. Taken at bedtime, they generally induce comfortable evacuation of soft, well-formed stools the next morning.

When the sun is up. Not at 2 a.m.

Patients like economical, easy-to-take SENOKOT Tablets. So do physicians. That's why they have widely prescribed SENOKOT preparations for over a decade.

Dosage (preferably at bedtime): *Adults:* 2 tablets (max. 4 tablets b.i.d.).

Contraindication: Acute surgical abdomen.

Supplied: Bottles of 50 and 100 tablets.

**Bibliography on request.*

The Purdue Frederick Company
Yonkers, N.Y.

©COPYRIGHT 1967, THE PURDUE FREDERICK CO. E-206867R



MICHIGAN STATE MEDICAL SOCIETY

120 West Saginaw (P.O. Box 152)
East Lansing, Mich. 48823
Area Code 517, 337-1351

1010 Antietam Road
Detroit 48207
Area Code 313, 965-0541

PRESIDENT..... James J. Lightbody, M.D.....Detroit
PRESIDENT-ELECT.. Robert J. Mason, M.D.....Birmingham
SECRETARY..... Kenneth H. Johnson, M.D.....Lansing
TREASURER..... John R. Ylvisaker, M.D.....Pontiac
SPEAKER..... James B. Blodgett, M.D.....Detroit
VICE-SPEAKER..... Vernon V. Bass, M.D.....Saginaw
PAST PRESIDENT.... Bradley M. Harris, M.D.....Ypsilanti

COUNCIL CHR..... Ross V. Taylor, M.D.....Jackson
VICE-CHAIRMAN.... Ralph R. Cooper, M.D.....Detroit

COUNCILORS:

Sidney Adler, M.D.....1st.....Detroit
Ralph R. Cooper, M.D.....1st.....Detroit
Don W. McLean, M.D.....1st.....Detroit
Milton R. Weed, M.D.....1st.....Grosse Pointe Park
Robert K. Whiteley, M.D.....1st.....Detroit
Ross V. Taylor, M.D.....2nd.....Jackson
Harvey C. Hansen, M.D.....3rd.....Battle Creek
Don Marshall, M.D.....4th.....Kalamazoo
John R. Pedden, M.D.....5th.....Grand Rapids
Harold H. Hiscock, M.D.....6th.....Flint
John J. Coury, M.D.....7th.....Port Huron
A. Carl Stander, M.D.....8th.....Saginaw
Robert V. Daugharty, M.D.....9th.....Cadillac
Edward H. Rodda, M.D.....10th.....Bay City
Brooker L. Masters,.....11th.....Fremont
Wm. A. LeMire, M.D.....12th.....Escanaba
J. Robert Franck, Jr., M.D.....13th.....Wakefield
Harold F. Falls, M.D.....14th.....Ann Arbor
Sydney Scher, M.D.....15th.....Mt. Clemens

EXECUTIVE DIRECTOR...Hugh W. Brenneman East Lansing
ASSOCIATE EX. DIR..... Warren F. Tryloff....East Lansing
GENERAL COUNSEL.....Lester P. Dodd.....Detroit
LEGAL COUNSEL.....A. Stewart Kerr.....Detroit
ECON. CONSULTANT.....Clyde T. Hardwick.....Detroit

SCIENTIFIC EDITOR
John W. Moses, M.D., Detroit

EXECUTIVE EDITOR
Herbert A. Auer

MANAGING EDITOR
Judith Marr

ASSOCIATE SCIENTIFIC EDITORS
Frederick J. Cady, Jr., M.D., Surgery
Saginaw
Robert M. Daugherty, M.D., Basic Science
East Lansing
Harold E. De Pree, M.D., Medicine
Kalamazoo
Dean C. Elliott, M.D., Otolaryngology
Petoskey
Tommy N. Evans, M.D., Obst.-Gyn.
Detroit
Dorin L. Hinerman, M.D., Pathology
Ann Arbor
Samuel D. Jacobson, M.D., Medicine
Detroit
Benjamin Jeffries, M.D., Psychiatry
Detroit
Raymond S. Kurtzman, M.D., Radiology
Detroit
A. Martin Lerner, M.D., Medicine
Detroit
George H. Lowrey, M.D., Pediatrics
Ann Arbor
Carl A. Moyer, M.D., Surgery
East Lansing
Charles E. Parkinson, M.D., Radiology
Battle Creek
John C. Pierce, M.D., Medicine
Grand Rapids
Frank H. Power, M.D., Surgery
Traverse City
J. G. Turcotte, M.D., Surgery
Ann Arbor
Alexander J. Walt, M.D., Surgery
Detroit
Park W. Willis, III, M.D., Medicine
Ann Arbor
Richard E. Wunsch, M.D., Medicine
Traverse City

Publication Committee

Brooker L. Masters, M.D.
Harvey C. Hansen, M.D.
William A. LeMire, M.D.
Don Marshall, M.D.
Don W. McLean, M.D.
Edward H. Rodda, M.D.
Milton R. Weed, M.D.

Pertofrane®, desipramine hydrochloride
Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg. in bottles of 100 and 1000.
(B) 46-530-E

For complete details, please see the full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

You decide who needs how much antidepressant and how much tranquilizer—

PRESCRIPTION POWER



Pertofrane can give rapid antidepressant action often within 3 to 5 days.
Levels of psychomotor activity, patient outlook and related somatic complaints may improve.

Pertofrane is well tolerated by most patients and adverse reactions are usually mild. A few serious side effects have been reported infrequently. Consult full prescribing information before using. It's summarized above.

Anxious Depressives...
May require adjunctive use of tranquilizers; but they don't always fit ready-made drug combinations. Isn't it better for *you* to decide who needs how much of which drugs?

Choose Pertofrane and pick your tranquilizer of choice. With this "combination", control the individual drug dosage adjustments that may be necessary for proper therapy. Isn't that the way it ought to be? Please remember, phenothiazine tranquilizers may aggravate depression, and never use Pertofrane with an MAO inhibitor.

PERTOFRANE®
DESIPRAMINE HYDROCHLORIDE **Geigy**

FIGHTS DEPRESSION

Questionnaire Studying Physicians' Post-Grad Needs In Hands of 1,600 Michigan Doctors

A detailed and lengthy questionnaire studying the attitudes of 1,600 Michigan physicians toward their postgraduate educational activities and their perceived learning needs will soon be in the mails.

Approximately one out of every six doctors in the state will receive the study, authorized and granted by the Michigan Association of Regional Medical Programs (MARMP) and drawn up by the Center of Research for the Utilization of Scientific Knowledge (CRUSK) at the University of Michigan. It will be mailed early in March.

The survey itself has been preceded by a letter from CRUSK telling about the study and asking the doctors cooperation in completing it.

The survey team, led by Floyd C. Mann, Ph.D., CRUSK director and project director, hopes to have all questionnaires back for study in the spring, with release of a written report scheduled for late summer or early fall.

Co-director of the study is Neal A. Vanselow, M.D., Ann Arbor, associate professor of internal medicine and associate professor of postgraduate medicine at the U of M, while MSMS representatives on the survey committee are C. Allen Payne, M.D., and John Moses, M.D.

According to Doctor Vanselow, the purposes of the study are to find what physicians' attitudes are toward the educational materials offered in Michigan from the universities and the MSMS, to discover what the physicians would like to have offered in the future that is not available now, to define the pressures from work, families and finances that prevent some physicians from keeping up as well as what factors motivate others to keep up with continuing education.

"This study should be of great help to medical societies and to medical schools in formulating future plans regarding medical education," says Doctor Moses.

"The questionnaire is rather lengthy and we realize that answering it will require time and may create difficulties," he continues, "However, we ask the physicians' support and strongly request that they complete the survey so that their medical society may be of better service to them.

"Nobody knows where we're going in medical education right now," says Doctor Moses. "There are continuing questions — are we using the right materials? Could we do a better job? Would it be better for a physician to take off to California and relax? Should he spend periods of time at home studying?"

Medical schools have suddenly realized that a physician spends more time on education after he graduates than when he's in school, observes Doctor Moses. All the stress in current government programs is also on continuing education.

"So everyone is in the act now," he comments.

MARMP's purpose is to disseminate information on the latest developments to the physicians, he says. Thus the reason for the study.

Urges More Doctors Purchase, Use Plaques To Explain Fees

BY BROCK E. BRUSH, M.D., CHAIRMAN
MSMS PUBLIC RELATIONS COMMITTEE

County medical societies can help promote better public relations by actively urging practicing members to purchase and display the AMA Fee Plaque.

The plaques eliminate areas of misunderstanding between the physician and the patient. Often patients would like to discuss professional fees and services but may be hesitant. Physicians can encourage them to feel free about bringing up the subject of fees. The AMA plaque — suitable for wall or desk — is an open invitation for patient-doctor discussion.

The attractive 6" x 10½" plaque is lettered in white on a dark brown background to harmonize with any office decor. Its plastic covering and beige plastic frame assures protective durability. The plaque may be purchased for $1.25 each, postage paid, from Order Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.



Extract of MSMS Council Minutes

Meeting of November 6, 1968

Establishment of Citizens Committee on Medical Manpower. President-Elect Mason reported on the MSMS campaign for increased medical manpower suggested by the House through resolution and the President's Remarks. A Detroit meeting with lay leaders and doctors of medicine resulted in the creation of a statewide citizens committee with Doctor Mason and Mr. Warren Huff as co-chairmen. Additional regional meetings with lay community leaders were scheduled.

Endorsement of World Medical Relief. The Council renewed MSMS endorsement of World Medical Relief.

HEALTH PLANNING. The Council authorized a communication to all MSMS component societies requesting them to thoroughly investigate all existing bases in their areas which could be expanded into regional comprehensive health planning councils and further requested component societies to make every effort to both gain adequate representation on such bodies and influence their development to the point of recognition as the authoritative planning group in the area. The Council also requested staff to research the present degree of physician participation in all types of planning bodies presently constituted in Michigan.

Report of Michigan Medical Service. Mr. John C. McCabe presented a brief verbal report in addition to a written report and entered into a discussion with members of The Council regarding participation figures and the criteria used for establishing reasonable charges.

MEDICAL EDUCATION. The Council had an in-depth discussion on medical education and the future needs of medical schools, and adopted four recommendations, after consultation with representatives of the three medical schools:

1. The State Board of Education should strongly reaffirm to the Legislature its previous recommendations concerning the expansion to optimum size the two existing degree-granting medical schools in Michigan, and should especially emphasize the immediate urgent needs of the Wayne State University School of Medicine.

2. The State Board should recommend that Michigan State University be provided with adequate funds to immediately expand to a degree-granting medical school and also to expand to its optimum size.

3. The State Board should recommend to the University of Michigan, Wayne State University, and Michigan State University that studies be initiated concerning the possibility of offering students the option of an MD or DO degree. The Michigan State Medical Society will be glad to cooperate and assist in every way in this endeavor.

4. The State Board should consider that after the three present medical schools are expanded to their optimum there will be needed in Michigan a fourth and probably a fifth medical school. Any new school unquestionably should have an appropriate university or college affiliation and also be able to develop the facilities for education and ancillary medical personnel. Consideration of an osteopathic medical college may be studied providing any new medical college also be required to offer the MD or DO degree option.

FORMER COMMITTEE HEAD, DOCTOR ROSS, RETIRES

C. Howard Ross, M.D., Ann Arbor, a former chairman of the MSMS committee that provides lecturers on medical ethics and economics for the U-M medical students, has retired at the age of 68.

Doctor Ross also has contributed much over the years to the MSMS Committee on Postgraduate Medical Education and the Aging Committee.

A past president of the American Medical Writers Association, Doctor Ross periodically has contributed original articles to *Michigan Medicine*. He is working now on an autobiography, "A Doctor's Philosophy."

A former high school science teacher, Doctor Ross went into medicine at the age of 41 after graduation from the U-M Medical School, and had practiced in Ann Arbor ever since.

Ottawa Society, Holland PTA Attract 2,000 to Sex Education Meet

The Ottawa County Medical Society and the Holland City PTA Council in October announced a sex education program for interested mothers and daughters for November 26.

"How many would come?"

"Where should the meeting be held?"

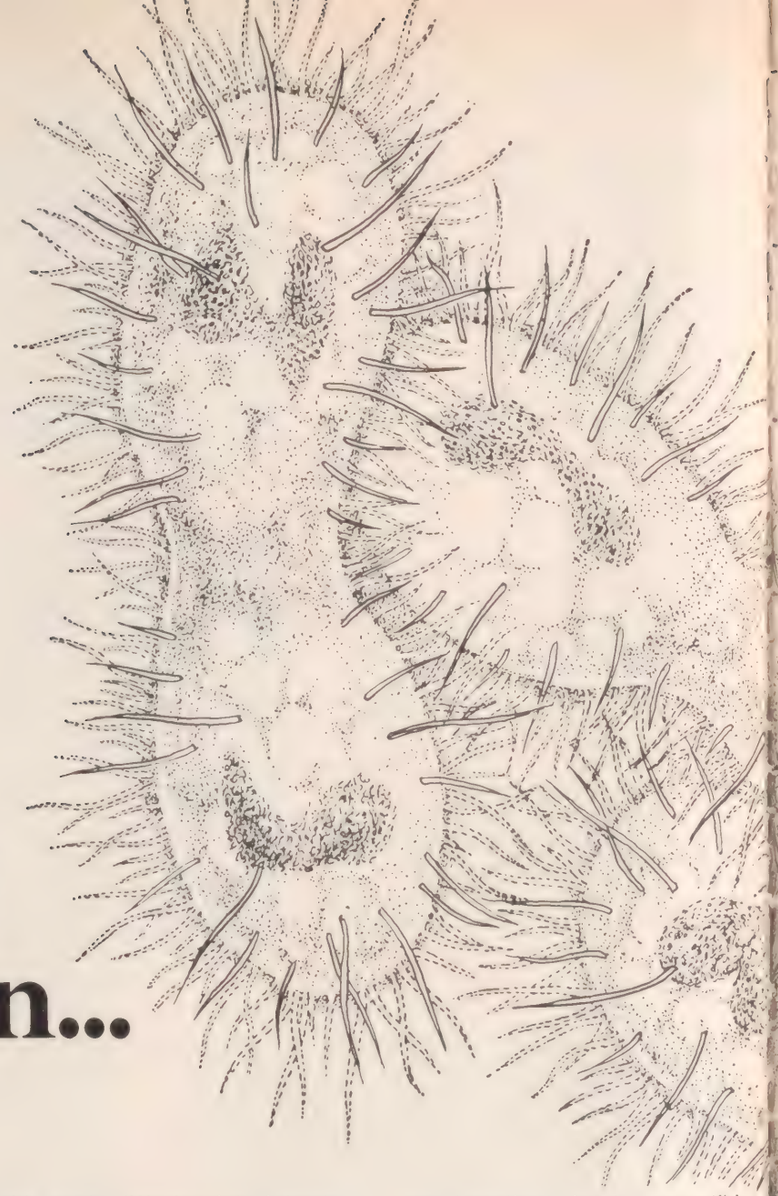
These questions and others were considered. The Holland Civic Center was obtained.

The Civic Center with its 1,500 to 1,800 seats was not big enough when about 2,000 mothers and daughters arrived. Extra chairs were quickly set up.

The companion program for fathers and sons drew about 1,500 on December 17.

The Ottawa County Medical Society — as could be expected — is planning more free town-hall meetings on health subjects.

A high index of suspicion... E. coli



How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

Consider wide-spectrum Gantanol® (sulfamethoxazole) for its high "index of confidence"—its proven effectiveness against *E. coli* and other sensitive gram-negative and gram-positive organisms. Therapeutic levels of Gantanol in blood and urine are achieved within 2 hours after a 2-Gm starting dose, with ready diffusion into interstitial fluids. Responsive infections generally clear within 5 to 7 days, with relief of symptoms usually seen within 24-48 hours.

Gantanol also earns its high "index of confidence" because Gantanol therapy is relatively free from complications, including the problem of bacterial resistance or superinfection.

Convenient, economical dosage schedule: *b.i.d.*

References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days.* Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

For a high index of confidence... Gantanol® (sulfamethoxazole) in antibacterial therapy

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Michigan Mediscene

Feb. 3-10 — Childrens Dental Health Week

Feb. 5 — United Cerebral Palsy Association of Michigan, Professional Advisory Council, Statler Hilton Hotel, Detroit

Feb. 5-7 — Michigan Department of Public Health 19th annual Director's Conference, Jack Tar Hotel, Lansing

Feb. 6 — American Cancer Society, Michigan Division, Board of Directors' Meeting, Jack Tar Hotel, Lansing

Feb. 11-13 — Michigan Tuberculosis and Respiratory Disease Association Annual State Planning Conference, MEA Conference Center, St. Mary's Lake, Battle Creek

Feb. 12 — Michigan Association for Regional Medical Programs Board of Directors meeting, Corporation Offices, 1111 Michigan Ave., East Lansing

Feb. 12 — Michigan Association for Regional Medical Programs, Regional Advisory Group meeting, East Lansing

Feb. 12 — MSMS Committee on Emergency and Disaster Medical Services, Sheraton-Cadillac Hotel, Detroit, 3 p.m.

Feb. 15 — United Cerebral Palsy Association of Michigan Board of Directors Meeting, Kellogg Center, MSU, East Lansing

Feb. 16 — Michigan Heart Association, Public Forum, Smoking and Health, Parkside High School Auditorium, Jackson

Feb. 17-18 — Chamber of Commerce Association Public Affairs Conference, Sheraton-Park Hotel, Washington, D. C.

Feb. 22 — Inauguratory Session of the American Association of the Professions, Detroit

Feb. 23 — Inauguratory Session of the American Association of the Professions, Malaga, Spain

Feb. 24-28 — National Communicable Disease Center, Flint-Genesee County Health Depts., Michigan Department of Public Health, "Principles of Epidemiology," Flint

Feb. 28-March 1 — Michigan Public Health Association Health Education Division Winter Meeting, Haven Hill Lodge, Milford

March 5 — Michigan Diabetes Association, Clinical Society, Stouffer's Northland Restaurant, Southfield

March 6 — Michigan Tuberculosis and Respiratory Disease Association, Board of Trustees meeting, Dines Restaurant, Lansing

March 11-14 — Michigan Academy of General Practice Annual Meeting, Sheraton-Cadillac Hotel, Detroit

March 12 — MSMS Council, MSMS Headquarters, East Lansing

March 20 — Second Annual Cancer Conference for Nurses, Michigan Division American Cancer Society, Rackham Building, University of Michigan

March 20 — Lansing Dietetic Association, MSMS Headquarters, East Lansing, 8:00 p.m.

March 21-22 — AMA 22nd National Conference on Rural Health, Philadelphia-Marriott Motor Hotel, Philadelphia

March 26-27 — MSMS 8th Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

March 28-29 — AMA 3rd National Congress on Socio-Economics of Health Care, Palmer House, Chicago

March 30 — Michigan Society of Internal Medicine, MSMS Headquarters, East Lansing, 11 a.m.

April 30 — MSMS Council, MSMS Headquarters, East Lansing, 9:30 a.m.

May 7-9 — Michigan Public Health Association Annual Meeting, Pick-Durant Hotel, Flint

May 21 — Annual Muscle Symposium, Wayne County Medical Society Auditorium, Detroit

May 22-23 — MSMS Annual Maternal Health Conference, Gull Lake

June 4 — MSMS Council, MSMS Headquarters, East Lansing, 9:30 a.m.

July 13-17 — American Medical Association Annual Meeting, New York City

July 31-Aug. 2 — MSMS Midsummer Session of The Council, Boyne Mountain Lodge, Boyne Falls

35 Michigan Papers, 15 Stations Carry Brenneman Essays

"The Human Side," a series of "brightener" radio programs, written and presented by MSMS Executive Director Hugh W. Brenneman, were aired on 15 radio stations in the state starting the first week in January.

The program, which was first broadcast over Michigan State University's radio station WKAR, in September as "The Art of Living," has 60 segments taking four and a half minutes of broadcast time each.

Topics range from "Personal Music of Yesteryear" to "The Transplantation of a Liver" and are also the subject of a series of columns Mr. Brenneman writes for six dailies and 35 weeklies in Michigan newspapers.

Both the programs and the columns are designed to share the knowledge of the professions and especially the medical profession with the public. They are "pocket treatises" offering ingredients of human sympathy and understanding while they deliver authoritative information on health and related matters.

The newspaper columns are edited versions of the radio programs.

Statewide Campaign for Medical Self-Help Launched by Woman's Auxiliary To MSMS

The Woman's Auxiliary to the Michigan State Medical Society has launched a campaign urging all adults and children in Michigan to take instruction in medical self-help.

First step in the campaign, according to Auxiliary President Mrs. Earl E. Weston of Birmingham, is to get all Auxiliary members to take the medical self-help course developed by the Public Health Service and HEW in conjunction with the Office of Civil Defense and the Department of Defense.

Mrs. Weston received approval of the Auxiliary's promotional campaign at the Dec. 18 meeting of The MSMS Council. The Council concurred in the need for the project.

Her next move was to submit a call for participation through the *Auxilium,* newsletter of the Auxiliary. She also contacted state extension leaders to try to involve other women's organizations in the educational drive.

The medical self-help program is a series of 11 lessons taught according to a kit of instructions distributed to all county Civil Defense directors. Teachers include Red Cross personnel, doctors, nurses, health department personnel and sanitarium staff members.

The self-help program (more complete than the Red Cross first aid course) includes a section on emergency childbirth delivery, as well as instructions on what to do in case of natural disasters, highway and home accidents.

The classes are available in every Michigan county and are taught in 400 of the state's approximately 800 schools as well as Michigan State University, Hillsdale College and the University of Detroit, according to W. J. Hayes of the Michigan Department of Public Health.

In Detroit, the City Health Department has taken over the instruction and is preparing a corps of teachers under the Model Cities program, to improve the public health of the inner city.

The Auxiliary campaign will be headed by the Safety-Disaster Preparedness Committee, chaired by Mrs. James Ferguson of Grand Rapids, who has herself taken the course.

"The more women we can get interested the more work we can get done," says Mrs. Weston. "It's a matter of informing people, to save lives that are otherwise lost."

"Auxiliary members should be the first to show interest."



ANCILLARY

U-M PUBLIC HEALTH SCHOOL ANNOUNCES MASTER'S PROGRAM

The University of Michigan School of Public Health has announced an expanded graduate program in chronic disease, adult health and aging, leading to the Master of Public Health degree. It will prepare students for careers as administrators, consultants, and specialists in disease prevention and detection programs, care and rehabilitation of the long-term patient and services for the aging.

Students with a bachelor's or an advanced degree in the health fields or the social sciences are invited to apply. The program of study can be completed in one or two years.

Traineeships are available for qualified students and range from $2,400 to $7,000 per year, plus an additional $500 for each dependent and full tuition. Traineeships are tax exempt.

Those interested may write Ian T. Higgins, M.D., Program Advisor, Chronic Disease, Adult Health and Aging, The University of Michigan School of Public Health, Ann Arbor, Mich. 48104.

DOCTOR WESTOVER RECEIVES PLAQUE OF APPRECIATION

Charles J. Westover, M.D., Plymouth, was presented a plaque of appreciation from his fellow physicians recently on the occasion of his retirement. Doctor Westover left practice in December after serving more than 20 years in Plymouth.

Smiles speak louder than words

for the good taste of Soyalac

Milk-free, hypo-allergenic Soyalac has a pleasing taste that is eagerly accepted by most infants. It's similar to mother's milk in composition and assimilation, much like cow's milk in consistency and completely free of fibre. Extensive clinical data support Soyalac's value in promoting growth and development. Soyalac is also excellent for growing children and adults.



Available in
Concentrated Liquid or Powdered

Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.

Soyalac

a product of
LOMA LINDA FOODS
MEDICAL PRODUCTS DIVISION
RIVERSIDE, CALIFORNIA
Mount Vernon, Ohio, U. S. A.



The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220

A·H·ROBINS

YOUR DISABILITY INCOME PLAN IS NOW A BETTER BUY THAN EVER!

INCREASED INDEMNITY

You can now purchase a monthly benefit of up to $1,000. (The former limit was $500.) If you also have additional coverage, Provident will participate in total coverage providing up to $2,500 a month in benefits. These limits are subject to 55 percent of earnings. And remember, your disability income benefit is tax free.

CONVERSION GUARANTEE

You have a conversion guarantee in case the plan is terminated or in case you move your practice outside Michigan. You can convert to an individual policy, providing exactly the same coverage and benefit, and guaranteed continuable to age 70.

EXTENDED BENEFITS

If you are currently insured and your sickness benefits are payable to age 65, your sickness benefit is automatically extended to lifetime payments for sickness disability beginning prior to age 50.

ABBREVIATED MONTHLY BENEFIT AND ANNUAL PREMIUM SCHEDULE

Attained Age on Effective Date & Renewal Ins.	Monthly Indemnity	Lifetime Accident 5 Years Sickness (L-5 Plan)	Lifetime Accident Sickness to Age 65 (L-65 Plan)
Thru 33	$500	$ 63.50	$ 88.50
Cost for each additional Monthly Indemnity	$100	11.90	16.90
34 - 49	500	151.70	201.70
Cost for each additional Monthly Indemnity	$100	28.70	38.70
50 - 65	500	214.60	264.60
Cost for each additional Monthly Indemnity	$100	41.20	51.20
60 - 65	500	214.60	214.60*
Cost for each additional Monthly Indemnity	$100	41.20	41.20*

* Renewal Only

Semi-annual premiums are one-half the amounts shown above

BEN P. STRATTON AGENCY, INC.
MSMS Insurance Administrators
P. O. Box 547, Lansing, Michigan 48903
Telephone: (517) 484-2578

See next page for prescribing information



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specifics in acute otitis media

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, the most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strains may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged action permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity, onycholysis and discoloration of the nails (rare). Kidney—rise in BUN apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

398-

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.



"The inconvenience of a cold"

For a cold, NTZ® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTZ is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTZ Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTZ is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

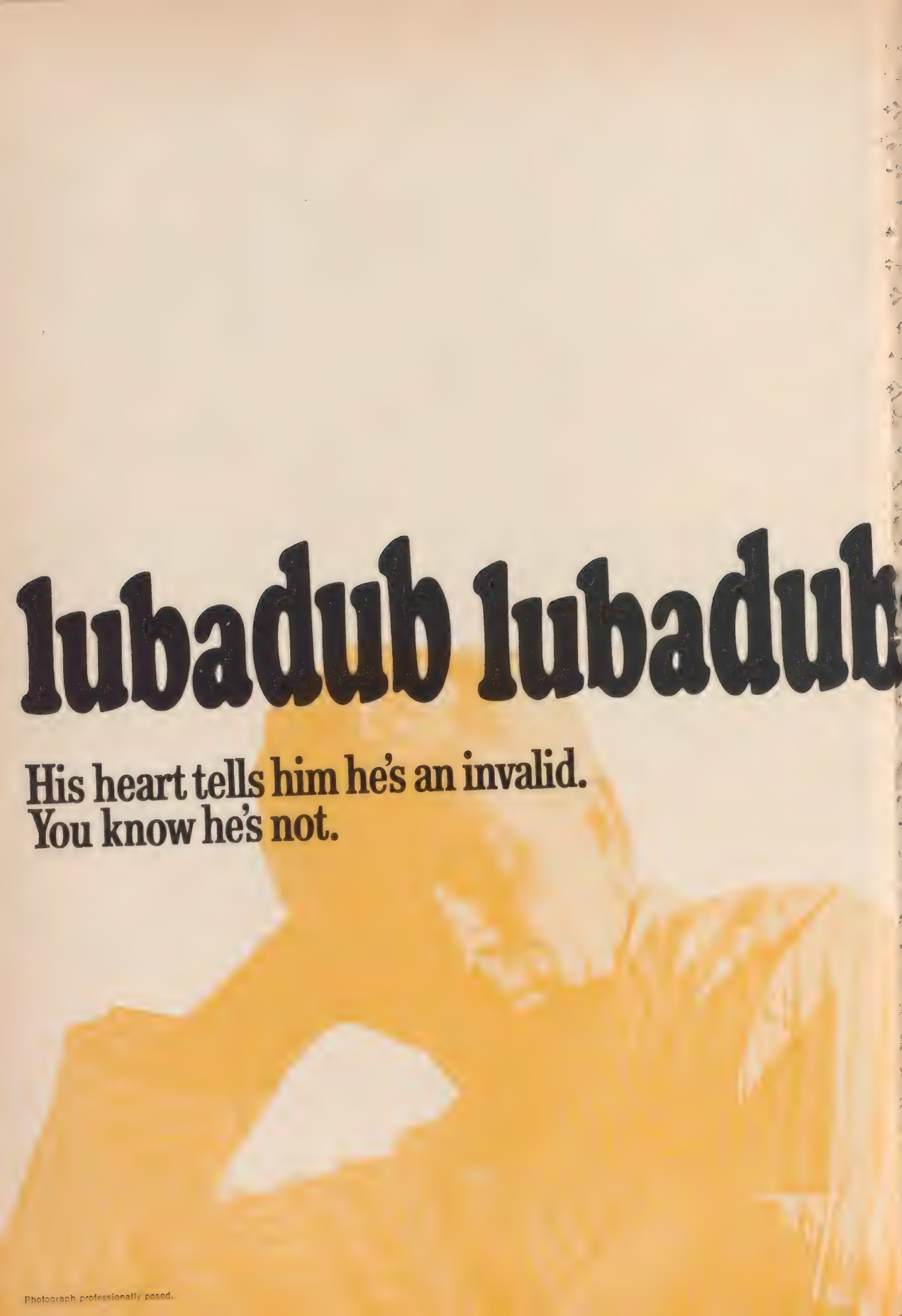
Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

lubadub lubadubbadubdub lubadu

His heart tells him he's an invalid. You know he's not.



Photograph professionally posed.

Anxiety is expected in the cardiovascular patient. A little may even be desirable.

But when anxiety is exaggerated . . . when it interferes with sleep . . . when it aggravates cardiovascular symptoms, your help may be needed.

Naturally, you'll want to reassure the patient.

And perhaps prescribe Equanil (meprobamate) as adjunctive therapy. It helps relieve anxiety and tension specifically, yet gently.

Almost 15 years' use has shown that Equanil is usually well tolerated as well as effective. Side effects are generally limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) Wyeth



The two-stage power of the pink pill for U.R.I. symptoms is nothing to be sneezed at.

The immediate and continuous-release actions built into each Novahistine Singlet can give most of your patients prompt and long-lasting relief from symptoms of upper respiratory infection, including fever, aches and pains.
Not only does Novahistine Singlet provide a vasoconstrictor-antihistamine formulation to reduce congestion and help restore normal ciliary activity; it also contains an antipyretic-analgesic compound to relieve the fever, aches and pains that so frequently accompany upper respiratory infections.
A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Pitman-Moore Division of
The Dow Chemical Company,
Indianapolis, Indiana.

Novahistine®
Singlet decongestant-analgesic
(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (*see* Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

900134 **Additional information available to physicians upon request.**

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

The Future of Private Practice: Salvation at the Grassroots

BY LEWIS A. MILLER, EDITOR
PATIENT CARE
STAMFORD, CONN.

I. FALLIBLE FORECASTS

Any commentator on the future of medicine finds himself in the difficult position of having to look to the past before he can prognosticate. Having done so, he becomes aware that predictions about the patterns of medical practice have been much less valid than those concerning the spread of Communism or the conquering of space.

To illustrate, I invite you to take the following 30-second test, checking each statement true or false:

"Most physicians in the United States today are working a shorter work week than they did in 1956." __True __False

"Three out of four physicians are in partnership or group practice." __True __False

"Medical schools are turning out a higher percentage of general practitioners this year than any time since the early 1930s." __True __False

"All osteopathic physicians now have MD degrees and all former colleges of osteopathy now are turning out medical doctors." __True __False

"Closed panel comprehensive prepaid medical care plans are providing for a large minority of Americans and soon will take care of more patients than practitioners working on a fee-for-service basis." __True __False

"Net incomes of physicians in private practice have leveled off over the past three years." __True __False

AS YOU KNOW, EVERY statement in the preceding paragraphs is false. Yet each represented a consensus prediction of some 400 medical leaders in 1956, when asked by *Medical Economics* to outline the shape of medical practice ten years hence.

Why were their forecasts so far off base? With hindsight, it appears that the medical leaders of 1956 focused more sharply on what would be needed than what would be accomplished by 1966. Reading between the lines of the predictions, we can translate them into a statement of need as follows:

"Physicians need to fit into more highly organized forms of practice and to function more efficiently. Patients need family physicians who are concerned about total health care and about the physician-patient relationship as well as the diagnosis and treatment of disease. Medicine needs to break down its walls excluding osteopathic physicians, as well as medical doctors who are willing to work on salary for a closed-panel plan. Physicians need to accept a leveling-off in fees and in income after a rapid, uncontrolled spurt."

As you can see, there is a sizeable gap between what might be called a reasonably accurate assessment of need and an unrealistic appraisal of expected accomplishment. In the pages that follow, I expect to share with you (1) a brief speculation on the reasons for this gap, (2) a statement on some of the problems and needs currently facing physicians in what I call the planned medeconomy and (3) a set of proposals designed to offer some partial solutions. As you read, I hope you will underline, strike out and argue in the margins — and in doing so, find fuel for the

THE FUTURE OF PRIVATE PRACTICE: SALVATION AT THE GRASSROOTS

This article includes these sections:

I. Fallible forecasts
II. Assessment without accomplishment
III. The forces of change
IV. The planned medeconomy
V. Reevaluation of existing Government programs
VI. Expansion of Government programs
VII. Expansion of voluntary health insurance
VIII. The problem of increasing controls
IX. Evaluation of physician performance
X. A proposal for organization
XI. Conclusion

fires of your own intellect. For this discussion is intended neither to promulgate a definitive program of action nor to serve as an infallible forecast, but simply to stir thinking physicians to considered action.

II. ASSESSMENT WITHOUT ACCOMPLISHMENT

Those medical leaders who have accurately foreseen the changing needs of medical care in the United States have consistently failed to foresee how those needs would be met. There are two over-simplified reasons for this failure to make accurate forecasts:

1. They have overestimated the power of wishful thinking to change patterns of human behavior and thus bring about a desired end.
2. They have underestimated the mass inertia of 200,000 fiercely individualistic father-images.

Two parallels come to mind within the framework of day-to-day medical practice that illustrate how these factors work against accomplishment: cigarette smoking and obesity.

The evidence is substantial, that cigarette smoking and obesity — each in its own insidious fashion — contribute to morbidity and mortality. Yet the annual consumption of coffin nails has not been markedly diminished by pronouncements from the U.S. Surgeon General or by personal persuasion by the family physician. Nor has there been a noticeable decrease in the number or poundage of overweight Americans.

Psychiatrists and behavioral scientists would be able to analyze the reasons for failure in these areas more acutely than I. But even to the casual observer, it is apparent that it takes more than the threat of a shortened or handicapped life to convince a man to give up a habit that appears to satisfy a need. The heavy smoker consciously or unconsciously takes his chances of dying of lung cancer or of being permanently attached to a nebulizer rather than accommodate his way of living to tobacco-less days. The overweight businessman will risk early death from coronary artery disease before he'll change his eating habits.

IF A PHYSICIAN, with his years of training and experienced insight, has so little success in selling individual patients on changes in behavior patterns, can we expect that the physician himself will be sold on an equally radical departure from his way of life? Remember that from day-to-day the practitioner dispenses wisdom that for the most part goes unchallenged by his patients. This built-in sense of assurance makes it hard for him to even consider rationally the possibility that traditional methods of practice may be completely outdated.

As a matter of fact, the physician's practice may well be as powerful a supporting habit for him as is cigarette smoking for the heavy smoker. The stresses of day-to-day patient care, with the implicit need to keep up with burgeoning scientific knowledge, are perhaps easier to bear in the old-shoe comfort of traditional solo, fee-for-service practice. When the patient sits down at your desk, you know he's been through certain preliminaries with your aide and perhaps spent 15 to 30 minutes in a period of waiting-room adjustment; you know that you can reach into a medical folder full of odds and ends of your own diagnostic and therapeutic shorthand; you know that come the end of the month, a bill for a fee you determine yourself will go out to the patient; and you know that, with few exceptions, no one ever checks to determine if you made the right diagnosis or prescribed the most efficacious therapy.

This comfortable practice habitat is not easily changed, even when the physician is warned of the impending "death" of private practice or the crippling advent of "socialized medicine." For doctors, like smokers, are not easily shaken by scare tactics, coercion or even friendly persuasion. Exhortations to group practice or to new forms of family practice or to new methods of payment for service are met with understandable resistance to change and a desire to cling to the familiar trappings of traditional medical practice.

III. THE FORCES OF CHANGE

If the individual physician is not motivated to change the status quo, is there any salvation for him from the spreading quicksands of "socialized medicine"? At the risk of joining the ranks of wishful thinkers, I believe there is. The road to salvation starts by making a realistic assessment of the physician himself, his ability to change and the motivation that will prompt him to do so.

There are those who say that all socio-economic progress in medical care has been the result of pressures from outside medicine — pressures from

This article is one of a series commissioned by the MSMS Committee on Medical Socio Economics.

patients, labor, industry, health insurers and government. The statement has unfortunately been true about 90 per cent of the time. Physicians have traditionally used the strength of their major organizations to fight against outside influences. They have lost most of the battles, regained their strength after adapting to new — and imposed — ways and then been threatened again. This cycle has got to be broken.

Let us begin by making a realistic estimate of the physician's characteristics as they relate to his mode of practice. These characteristics are reflected in the following ten statements. (Granting widespread exceptions):

1. The physician takes pride in the services he renders to his patients.
2. The physician practices his own combination of art and science. Each practice, like a fingerprint, has subtle differences from all other practices.
3. The physician is accustomed to making all his own decisions in practice, even the decisions of when to seek help.
4. The physician enjoys this feeling of independence and resents any efforts to curb it.
5. The physician wants to be paid on a fee-for-service basis, with a direct relationship between his income and the quantity and quality of his work.
6. The physician prefers to determine for himself the factors governing his economic progress: fees, patient load, working pace, working hours, office location and overhead, collection policies, etc.
7. The physician wants a controlled practice with adequate time off and time to keep up in his field.
8. The physician is a short-term problem-solver, seeing his patients on a highly organized basis, but is not inclined by nature to be a long-range planner.
9. The physician relates well to his individual patients in a practice setting, but often finds it difficult to assume a layman's role in the non-medical world.
10. The physician works well with his colleagues when he is seeking help with a medical problem, but he reacts poorly to being placed in a subordinate relationship to any other physician.

THE PHYSICIAN, THEN, is a loner, though he may belong to a myriad of organizations. His professional freedom is a vital part of his make-up though he may by choice surrender his control of a given patient to a consultant whom he respects. His ability to schedule his time is unusually good, though he may have trouble planning two years ahead.

The physician's ability to change is limited by those factors. Because he is a decision-maker himself, he finds it difficult to accept decisions handed down by others. Yet he can no longer journey isolated from the mainstream of American life, which today is built around organization. Organization implies vertical as well as horizontal relationships among people.

If the physician is to enter into a new kind of organization in medicine that relates to the world around him, he must be motivated to accept change in the patterns of practice. One key to motivation lies in building new patterns from old, keeping the values of individual judgment and professional freedom in whatever form of organization may be proposed. This is both necessary and extremely difficult to accomplish.

Much of the success of motivation depends on the attitudes of physicians who are in positions of leadership or who have the capability to lead. If medical men in positions of responsibility continue to wear their "abandon-hope" buttons, the mass inertia of 200,000 physicians will continue to smolder with coals of resentment, and will never be stirred to action. Too often a medical leader has asked himself, "Aren't we all going to be socialized within the matter of 10 years?" and answered in despair, "I see no alternative. The government is taking us over, and there's nothing we can do about it."

THAT KIND OF pseudo-Calvinistic philosophy has no place in medical leadership. The current status of medical practice in the United States is not irretrievably headed toward socialism. There *are* alternatives to existing patterns of practice — alternatives that can meet the changing needs of our society and at the same time satisfy most, if not all, the individual needs of the physician. It must fall to a relatively small group of optimistic, hard-headed activists in medicine to explore these alternatives and to sell them to their colleagues. And these men must put their ideas across at the community level, not the national level, first to be truly effective.

"The current status of medical practice is not irretrievably headed toward socialism."

In the pages that follow you will find some ideas for alternative patterns of practice that

seem to me to fit the physician's unique characteristics and his ability to change. There are others of equal or greater merit. The choice is not important. Action is.

IV. THE PLANNED MEDECONOMY

The theme of my discussion from this point on is private practice in the planned medeconomy. By private practice I mean any practice controlled by one or more physicians in which payment is made either on a fee-for-service or a comprehensive prepaid basis. By the planned medeconomy I mean the combined effort by physicians, hospital trustees, administrators, health insurers and government to provide the best level of medical care for the most people.

The term "planned medeconomy" is descriptive of the changing nature of this combined effort. Providing medical care used to be pretty much a function of doctors and hospitals. Payment for care came mostly from people who could afford to pay, plus token payments from Government and voluntary welfare organizations. Gradually, more organizations moved into the picture through the growth of voluntary health insurance. Labor, management and principally the health insurers themselves have taken a larger and larger role in paying for health care over the past 20 years. In most areas today, the nature of medical and hospital services and the levels of payment have been strongly influenced by these third parties.

With the advent of Medicare and Title 19, the government has become an immensely more powerful force in the medeconomy, posing some new problems for other forces in the planned medeconomy.

THESE PROBLEMS ARE NOT unlike those that have faced American industry or organized labor in the past two decades. The federal government is in effect planning the American economy when the President rolls back a steel price hike, or sets guidelines for wage increases, or orders strikers back to work for a cooling-off period, or puts a ceiling on the interest rates paid by saving and loan associations. The government is planning future directions for the industrial economy through aid to depressed areas, through Job Corps programs to educate the culturally deprived and through setting standards for passing out Federal aid to schools, colleges, housing projects and small businesses. So far, the private sectors of American industry and labor have proved strong enough to prosper in a planned economy.

Whether or not the private sector of American medicine will be strong enough to prosper — or survive — in a planned medeconomy depends upon its ability to solve the problems presented by that economy.

Let's take a brief look at four key areas of concern:

1. reevaluation of existing government programs;
2. expansion of government health-care programs;
3. expansion of voluntary health insurance coverage; and
4. the expanding network of controls accompanying these new programs.

"The choice (of alternative patterns of practice) is not important. Action is."

V. REEVALUATION OF EXISTING GOVERNMENT PROGRAMS

As you know, three different approaches are embodied in the Medicare and Title 19 legislation. Part A of Medicare is financed from Social Security taxes and offers the elderly person a very specific package of first-dollar benefits for a limited time period only. Part B of Medicare is financed by voluntary contributions from subscribers matched by dollars from general tax revenues. It provides virtually unlimited benefits for medical services with some deductible features. And Title 19 offers about what each state wants to offer — in some states low-fee schedule payments for a limited number of medically indigent cases; in other states, usual fees for a much greater number of eligible persons.

It stands to reason that the Department of Health, Education and Welfare as well as members of Congress will watch the successes, failures and costs of each program very carefully over the next couple of years. At some point, it seems to me to make sense to revise existing legislation to:

1. set up a more uniform system for financing health care for those who need it;
2. provide a logical pattern of benefits to fit the needs of those covered; and
3. provide controls and restrictions so that the costs of each program can be accurately projected and can be justified in terms of the services rendered.

IT'S TOO EARLY NOW to tell which approach will be soundest fiscally, medically and politically. Certainly you can bet on some revisions coming along in time for debate once the issues of Viet Nam and poverty have quieted down.

One approach to revising the Medicare program would be to do away with Parts A and B of Title 18 completely and to cover those elderly who need government-financed health care under the provisions of Title 19. Unfortunately, such a move would not be politically acceptable to leaders of either party.

A second alternative would be a revision of benefits to provide for long-term, catastrophic illness, with sizeable deductibles. Title 19 could then pick up the cost of the deductibles for those elderly who are medically indigent. At a time when medical care costs are rising so sharply, first-dollar limited coverage makes no fiscal sense for the government, the patient or the supplier of health services.

VI. EXPANSION OF GOVERNMENT HEALTH-CARE PROGRAMS

When the cost figures begin to roll in for Medicare and Title 19, I think legislators will go slow in adding new programs for the next few years. The reevaluation I mentioned is sure to come before any major expansion. So is implementation of other health-care laws passed in 1965-66. These include the heart disease—cancer—stroke program, the community mental-health program and the comprehensive health services program.

But any delay in expansion of government health-care programs is purely temporary. As our economy grows, and our nation has more money to spend, our political leaders will find new ways to spend it. I am not being critical when I say that — just realistic. Some of these new avenues of spending will surely be in the health field; in fact some proposals are already in the legislative hopper.

Senator Harrison Williams of New Jersey has proposed a network of health protection centers across the country to detect disease, with a three-year price tag of $60 million. Other proposals sure to get attention in the next few years include government-financed health care for children under 18, dental care for children, payment for drugs under Medicare, extended psychiatric care and extension of full Medicare benefits to the disabled and the unemployed.

I would expect to see more Federal programs such as these in action by 1972, hard on the heels of Medicare-Title 19 revisions.

"At a time when medical care costs are rising so sharply, first-dollar limited coverage makes no fiscal sense. . ."

VII. EXPANSION OF VOLUNTARY HEALTH INSURANCE PROGRAMS

There is already a pell-mell race of voluntary health insurance programs to catch up with and pass the government programs in scope of benefits.

Labor unions aren't satisfied to have their over-65 pensioners get bigger and better health benefits through Medicare than their sons get as working union members. So the unions are pushing to bring the level of benefits at least up to those offered under Parts A and B. The most immediate effect: Many more patients are getting coverage for office medical services.

That's not all. The UAW has won at the bargaining table coverage for short-term, outpatient psychiatric care and for convalescent or nursing-home care up to two years. Both these items are likely to be picked up in other union contracts in the next few years.

In that same time, insurers expect that unions will press for and win coverage for short-term psychotherapy, dental care, vision care and prescription drugs.

HOW ARE THESE NEW coverages coming into being? Not through physicians, hospitals, or even health insurers. They're coming alive because smart union leaders are looking for unfilled needs and getting them filled at the bargaining tables — with or without the support of physicians and hospitals.

This is an area in which organized medicine could immediately play a more important role. Each state medical society operating in a heavily industrialized state might appoint a full or part-time physician as health insurance counselor. His responsibilities would include keeping in touch with labor leaders and company officials on new types of coverage and working with the help of medical society committees to develop realistic programs to be presented at the bargaining table.

APPOINTMENT OF LIAISON persons might eliminate much of the confusion that new ensues when a new benefit comes into being, and is handed to physicians and hospitals to implement. For example, once short-term psychotherapy becomes a contract coverage, all sorts of problems

are likely to crop up: Psychiatrists will not have the time to fill the needs of union members for 15-minute-a-week sessions. If psychotherapy is provided by internists, general practitioners, or even obstetricians, who is to decide whether their services should be covered and at what fee? These and other questions might well be anticipated and answered before the fringe benefits were adopted, with the help of an M.D. health insurance counselor.

VIII. THE PROBLEM OF INCREASING CONTROLS

"He who pays the piper calls the tune." Less and less frequently, the patient pays the doctor or the hospital. The employer, the union and the government are the piper-payers in our planned medeconomy, and they represent strong, efficient organization — much stronger and more efficient than any existing organizations in the health-care field.

You can expect these highly organized third parties to press for standardization in all aspects of rendering medical care in the office and in the hospital. For one thing, each fiscal intermediary under Medicare — the Blue plan or commercial insurance company acting on behalf of the government in each area — is now developing profiles on each physician and his practice. At the start, only flagrant abuses are being picked up, just as they have been in the past by Blue Shield plans and other health insurance carriers.

But gradually the intermediaries will have a substantial body of data on office procedures, diagnoses and fees in their area. Similarly, the work done in each hospital will be profiled.

I CAN'T BELIEVE THAT these profiles will *not* be used at some point to develop what might be called "acceptable patterns of care" in a region. Obviously it is easier to develop profiles of care in hospitals than in office practice. Yet, from the mass of statistics on office care some patterns are bound to emerge that third parties will begin to take a hard look at.

In fact, one member of the Technical Advisory Committee on physician participation in Medicare has said, "It would be very naive for anyone to say there's not going to be a utilization review program covering patient care in the office — though it will probably take years to set up."

In addition, the dean of Mount Sinai Medical School in New York, Dr. George James has suggested that a jury of highly skilled physicians audit office care of patients covered by Government programs. "It makes no sense," he said, "to audit hospital and not office care, when only 10 per cent of all patient care is provided in the hospital."

And a California health-care advisor to labor and management, Glen Slaughter, has told the American Society of Internal Medicine that physicians brought government medicine on themselves by their failure to accept controls over the quality and costs of medical care. Here are a few of his remarks:

"Yours is the only U.S. industry which is almost completely geared to prepaid insurance for payment and yet has none of the normal insurance restraints.

"Neither patients nor doctors have wanted third party insurance adjusters interfering in the patient-doctor relationship. So all the burden of deciding what you and your hospitals were worth was placed on you, not on economic competition, not on normal insurance adjustment. There was no reward for virtue and great gain for the doctor who charged Beverly Hills prices.

"Then came the pressure for Medicare. And how were charges to be set under the law? The word was 'reasonable'. And when the regulations were issued, reasonable had been defined to mean 'usual and customary'. No contract negotiation, no bids, no standards — just whatever you usually charged your private patients.

"Now you have both private insurance and the taxpayer saying — 'Charge us what you will. You be the judge. We'll pick up the tab'. For that short-sighted, short-range advantage, you have sold your freedom. Neither the premium-paying nor the tax-paying public will continue indefinitely to underwrite a blank check for medical prepayment."

". . . a . . . health care advisor has told the ASIM that physicians brought government medicine on themselves. . ."

IX. EVALUATION OF PHYSICIAN PERFORMANCE

With more and more voices such as Dr. James' and Mr. Slaughter's being raised in the direction of controls, it appears to me that serious attention must now be given to the evaluation of physician performance — and this attention had better come from within medicine itself within the next two years, or it will surely come from other sources. Let's make a brief comparison:

Roger Smith is a farm equipment salesman. His work is evaluated daily by his sales manager. Mr. Smith is judged on his ability to develop new leads, follow up old ones, close a sale and produce dollar volume. If he's deficient in any skills necessary to the job, he gets criticism from his boss and on-the-job training; if he doesn't shape up, he may get fired.

Richard Roberts is a physicist employed by a large company to design components for a space vehicle. His boss, the chief physicist, evaluates Mr. Roberts' creativity, his aptitude in applied research and his ability to produce under pressure. A written performance report on his progress and potential goes to the research vice president of the company every three months for review.

Thomas Wright is a jet pilot. His airline and a federal agency regularly check out his skills and physical fitness to make sure he should continue to fly a 150-passenger airliner cross-country. Each time he flies, he runs the risk of being grounded, because he never knows when an inspector may be watching him.

George Brown is a family physician in solo practice. His fellow doctors on the hospital staff now review the records on his deliveries and are just starting to spot check his charts on coronary and stroke patients. But for the most part, Dr. Brown evaluates his own performance, particularly when care of office patients is concerned.

Unlike Messrs. Smith, Roberts and Wright, Dr. Brown has traditionally been free to establish the benchmarks for his own professional competence in office practice. He can determine his own standards for practice. These standards are likely to be based on three factors: first, his training and skills; second, the prevailing standards of medical care in the community, and third, the demands of his patients.

AS A RESULT, his performance rating comes not from a boss or a government agency but from three more loosely defined sources:

1. The opinions of his professional colleagues;
2. The satisfaction of his patients, and
3. His own subjective appraisal of how he's doing.

Increasing pressure is now developing to apply more rigid and less subjective methods to the evaluation of the skills and performance of a physician. The concern of third parties for evaluating the quality of care prompted Dr. James to voice his concern about auditing office care.

A REPORT OF THE National Advisory Commission on Health Manpower suggests basing relicensure upon either acceptable performance in continuing education programs or challenge examinations in the practitioner's specialty.

In quite a different context, another medical academician, Dean William N. Hubbard, Jr., M.D., of University of Michigan Medical School, has indicated that continual revaluation of the physician in all areas is a goal worth serious consideration. "If the value of a physician is to be measured," Dean Hubbard says, "we must develop devices to determine the frequency with which a physician's action may make a positive contribution to the health of the patient, or may do actual harm."

As Dean Hubbard implies, there are few objective standards existing today which can be used to measure the value of a physician's services. Does length of stay really provide such an indication? Or which laboratory tests are ordered? Or an autopsy report?

Criteria for evaluating quality of care in the hospital may not provide a true measure of value. Therefore it may be premature to extend hospital auditing procedures into the office, as Dr. James has suggested, until these two basic questions are settled:

1. Is it desirable to have periodic and required evaluation of a physician's performance, as is the case for a salesman, physicist or jet pilot?
2. Is it possible to develop widely applicable and valid criteria for the evaluation of medical performance?

FIVE YEARS AGO, it was easy to brush off such questions as both unwarranted interference in the private practice of medicine and also, in any case, almost impossible to answer. This is no longer true. The public is paying heavily now for massive government-sponsored health programs, and will do so in the future. It feels it has the right to evaluate what it is paying for. With the computerized systems of recording services and fees for programs such as Medicare, information is fast developing that could provide a basis for evaluation.

I urge, therefore, that doctors seize the initiative quickly in developing methods of evaluating the quality of care.

> ". . . serious attention must now be given to the evaluation of physician performance — and this attention had better come from within medicine itself. . ."

HERE ARE A FEW possibilities:

1. Let the local hospital medical staff serve as the grassroots unit for evaluating performance in the office as well as in the hospital. Develop a uniform medical record for office and hospital practice. Once staff members have adopted it, let an office medical audit committee spot-check records of each staff member periodically, much as hospital records are reviewed.

2. Let the state medical society set up a committee to work with the state's Medicare and Medicaid intermediaries to receive the pertinent records, interpret them and follow through with certain guidelines for distribution to member physicians. When the data red-flags the performance of a particular physician, the state society committee must be responsible for appropriate investigative action, whether taken by itself or a county medical society.

3. Let the American Medical Association work with the Department of Health, Education and Welfare, with the National Blue Shield and with other nationally represented intermediaries to develop a system for evaluating the kind of data being collected and the ways it is being used — or misused. It is possible that the information thus collected might enrich the proposals of the various specialty groups for periodic reexamination and continuing education of members.

We have reached the point in our planned medeconomy where it is purely academic to argue that periodic and required evaluation of a physician's performance is undesirable. It is coming. It is not too late, however, for physicians to have a strong voice in developing widely applicable, valid criteria for such an evaluation.

X. A PROPOSAL FOR ORGANIZATION

As you can see, the private practitioner faces some pretty rough sledding in the planned medeconomy. In the years ahead it will be tougher to practice solo; tougher to set and adjust your own fees; tougher to care for patients by the physician's own standards, without someone looking over his shoulder.

"The paramount requirement . . . is to build an effective national medical organization on a foundation of small, homogeneous units. . ."

With those restrictions on the horizon, what can a private practitioner do to preserve his professional integrity? How can he set up the kind of practice he wants within the framework of the planned medeconomy?

To a great extent, the answer lies with the leaders of medicine at the grassroots — the chiefs of staff and chiefs of service in community hospitals. Each has an opportunity that may not last forever — an opportunity to build in his medical staff an organization that can help private practice survive in the planned medeconomy.

It will not be easy to build such an organization; the traditional autonomies in medical practice die hard, as has been pointed out. But die they must, if physicians are to stand up to the pressures of government, labor, industry and health insurers. For several years, I have mouthed the same words that hundreds of others have: "The physician must be captain of the health-care team." As of this writing, I do not think the physician will be captain — in fact he may not even make the team — unless he plays the game the way the other players do: by the rules of organization.

WHAT CHANGES ARE NECESSARY to do this? The paramount requirement, I believe, is to build an effective national medical organization on a foundation of small, homogeneous units — the medical staffs in community hospitals. This kind of grassroots organization contributed to the strength of the Christian Church and the AFL-CIO, to name just two members of the power structure in today's society. It can give substantial new strength to the anemic body politic of the American Medical Association and its constituent state societies.

For the most part, the community hospital medical staff is not now organized to provide the basis for this new strength. Set forth here are ten steps to an organized staff, steps that must be sold over a period of time to attending physicians:

1. STRONG LEADERSHIP. This step is a prerequisite to the other nine. A medical staff can no longer be led by a president or chief of staff elected on a one-year basis, nor by chiefs of staff or service who remain in power in perpetuity. Medical staff leaders should have adequate time to develop and execute programs of action but then be prepared to turn the reins over to others and move into advisory roles.

Most community hospitals need a chief of staff or president whose term of office is either three years with a two-term limit, or five years with a one-term limit. This period of service provides a chief time to master the complexities of medical

staff management, to formulate ideas and to sell them to physicians, administrators and trustees.

The chief may be elected by the medical staff with ratification by the trustees, or appointed by the trustees with the approval of the staff; in either case, his responsibility for the quality of medical care is to the governing board of the hospital.

As a rule, the chief of staff should be a practicing physician with sound knowledge of his medical colleagues in the community, with proven executive ability and with the time to devote to the job. Depending on the size of the hospital and the time required to run the medical staff, the chief of staff may have to be compensated financially to make up for a loss in practice time. He should not be a fulltime administrator; fulltimers, however, may be needed as chiefs of service or directors of medical education in teaching hospitals.

2. PRIVILEGES FOR ALL, BASED ON ABILITY. There has been an unfortunate trend in some areas of the country, particularly in major cities, to deprive general practitioners of hospital privileges. The results can only be deleterious to good medical practice in the community, since deprivation of privileges forces these physicians to work in substandard hospitals or to handle hospital-type procedures in their offices.

Any physician entitled to practice medicine should be entitled to minimal admitting privileges in one accredited community hospital. His privileges beyond that point should be determined within each department to which he applies, according to his past record and to his current ability as demonstrated under supervision.

Medical staff leaders have a responsibility going beyond the determination of privileges; that is, to point out to any applicant his areas of deficiency and to help him correct these.

3. PRIVILEGES LIMITED TO ONE HOSPITAL. Most attending physicians (subspecialists excepted) should limit their work to one hospital. The time is rapidly passing when a man can spread himself among two or more hospitals and still play an effective role in organized medical care.

"Strong leadership . . . is a prerequisite . . . to an organized (hospital) staff. . ."

Two factors usually influence a doctor's decision to remain on several staffs: (1) the fear that beds for his patients will not always be readily available in one hospital, and (2) the fear that patients will insist on a choice of hospitals even at the price of changing doctors.

If there is a true bed shortage in the community it should be remedied by construction of additional facilities, not by physicians holding multiple-staff privileges. If this is not the case, then medical staff leaders, by making a careful assessment of bed utilization by physicians, should find it possible to tailor the constituency of the medical staff to fit.

As for the second fear, it might very well disappear if the doctor-patient relationship were as solid as most patients want it to be.

4. EDUCATION IN HEALTHCARE ECONOMICS. In 1966, hospital costs rose 16.5 per cent, medical costs, 6.6 per cent. Like it or not, the economic factor has to be part of the judgmental process in rendering good quality care, even though third parties are paying for the care; and doctors ought to make the judgments, not the third parties.

Medical staff leaders must find ways of making attendings aware of the comparative costs of office care, short-term hospital care, extended care and home care. They must also help staff physicians keep up with the new forms of health services now available to patients at low cost or no cost through social and community agencies. Since many doctors are just too busy to keep up with the myriad of services for themselves, it may prove useful to add a social worker to the hospital staff — not only to counsel patients, but also to advise physicians on a regular basis.

5. EFFECTIVE QUALITY-CONTROL PROGRAMS. Many hospitals are now on their way to accomplishing this objective. As a first step, each committee of the medical staff — utilization, medical records, medical audit, tissue, admissions, infections, patient care, etc. — should set up clear, workable criteria for operating, and *stick to these criteria.*

As noted previously in this paper, there is a need for developing methods of physician evaluation. These may well come about through techniques originated and tested within the community hospital medical staff. The establishment of adequate written standards of hospital care by diagnosis, while no substitute for more definitive measures of value, might be a start. These standards might cover such items as minimum laboratory and diagnostic tests, consultation, length of stay, etc.

Not only would development of written standards lead toward new ideas in medical perform-

ance evaluation, but it also would help undercut the pressure that is sure to come from third parties to adhere to standards produced by their computer print-outs.

6. UNIFORM MEDICAL RECORDS IN HOSPITAL AND OFFICE. One of the most inefficient areas in all medical care is medical record-keeping. Similar headaches, of course, exist in government and in industry; these sectors of the economy, however, are continually using the talents of systems experts to devise methods of recording, storing and retrieving information. Not so with the health industry — at least not until very recently.

It is not within the scope of this discussion to propose any specific health records system, but rather to set forth a concept: that of uniform medical records for hospital and office practice. Information on any patient should be readily transferable to the point of use, in order to eliminate duplication of effort, reduce the opportunity for errors of omission and provide a standard set of data for the optimum monitoring of patient care.

If, for example, office medical records were to follow the same format as hospital charts, certain aspects of an admitting workup might be omitted, thus saving the time of the physician and reducing the cost to the patient. Problems in pharmacotherapy might be avoided if a complete drug history were immediately available. And a consultant would have at his fingertips a wealth of long-term information about the patient to help him make an adequate evaluation as efficiently as possible.

7. CENTRALIZED BOOKKEEPING AND BILLING. As financial record-keeping becomes more and more complex — the result of more and more third-party payments — the rationale behind centralized bookkeeping makes more sense.

Commercial services have drawbacks, because they often are not geared to handling the complexities of medical service billing. A more satisfactory approach might be to set up a medical service corporation representing the hospital medical staff; this corporation could then contract for computerized services with the hospital or with a Blue Shield plan serving the area. In either case, each physician would continue to set his own fees, but would be free of much of the complicated burden of third-party paperwork.

"... each committee of the medical staff... should set up clear, workable criteria for operating, and stick to these criteria."

8. IMPROVED PHYSICIAN-PATIENT RELATIONSHIPS. Unfortunately, a number of factors have been working toward impersonal medical care in recent years: increasing specialization in medicine, increasing mobility of patients, heavier patient loads (particularly in family practice), more hospital-centered practice, and a rapid rise in third-party payments. Both doctor and patient are inclined to decry this trend, but neither do much to reverse it.

Unlikely as it may seem at first thought, there are possibilities for improved physician-patient relationships within the framework of a community hospital medical staff organization. The development of such an organization should eventually free the physician to spend more time with his patients and also ensure that he provides them with a consistently high quality of care.

Medical staff leaders must continue to foster the concept of long-term doctor-patient relationships. Care must be taken not to shift the burden of patient care from the individual physician to the medical staff as a whole or to its leadership. At the same time, the physician must recognize that his primary responsibility for patient care is to the patient himself, *regardless of who pays the bill.*

For these reasons, it is important that the patient continue to see his personal physician — or a consultant — in an office setting and on a personal appointment basis, rather than in a hospital clinic. For convenience, it may be helpful to locate more doctors' offices on or adjacent to the hospital grounds, as long as the patient is encouraged to seek out his own doctor rather than "the hospital" when he needs medical help.

The growing use of fulltime doctors in hospital emergency rooms can also work to the betterment of doctor-patient relationships — if the fulltime group is set up and regulated by the medical staff and regularly refers new (and old) patients to pivate physicians on the staff after rendering only emergency care.

9. MUTUAL RESPECT AND COOPERATION. As the preceding steps come into being, the hospital medical staff should develop into a cohesive group of physicians — not a group practice in the formal sense, but a group in terms of coverage and consultation arrangements, uniform medical and financial records, and common objectives in patient care.

In a teaching hospital, the medical staff so organized would be better able to cope with the

problems of fulltime staff and of assigning, charging and paying for services rendered by the house staff.

Such a group would offer each physician on the medical staff the freedom to work at his own pace, set his own fees and maintain his personal physician-patient relationships. At the same time, it would offer him a strong local organization dedicated to a high standard of cost-conscious care. Through this kind of grassroots organization, private practitioners can build the strength they need to work effectively with third parties without being worked over by them.

10. IMPROVED REGIONAL AND NATIONAL ORGANIZATION. Clearly the local medical staff, even when highly organized, can't go it alone and be effective in the planned medeconomy. There is a need for two types of regional and national organizations, one on a scientific level and the other on a political and economic level.

The first should come about through the expanding network of regional medical complexes approved by Congress. If possible, medical staff leaders in a region should work together to develop the kind of relationship with the university medical center that will be a two-way street. Medical center teachers and administrators, whether they know it or not, need to listen to the problems of first-line practitioners before setting up their regional programs.

The second type of organization, for political and economic purposes, probably must provide a new link between the community hospital medical staff and the state medical society. For the most part, the county medical society is as anachronistic as county Government. Perhaps the most realistic substitute would be a regional medical society, based on the same "boundary lines" as the regional medical complexes mentioned above. Such a regional society would represent a community of interest, and would be able to take advantage of lines of communication already opened for scientific purposes.

XI. CONCLUSION

If private practice is to survive in the planned medeconomy that now is a fact of life, medical leaders must take hold at the grassroots to develop new forms of effective organization.

Since most physicians do not respond readily to the idea of changing their patterns of practice, these new forms of organization should be built on existing foundations – principally on the foundation of the community hospital medical staff.

IF PHYSICIANS CAN BE motivated to accept certain variations on existing patterns of practice at the local level, I would then venture to predict for the future (1) improved standards of medical care; (2) physician participation in the planning of new medical care programs; (3) a reduction in third-party friction; (4) a revitalized doctor-patient relationship; and (5) a new sense of professional independence based on recognized measures of competence.

Did You Read the Six Scientific Papers in the January Issue?

Each month *Michigan Medicine* prints selected outstanding scientific articles. To date, the following papers (with month, page number and author following) have been published:

JANUARY

Page 31, *"Lower Lung Field Tuberculosis,"* by Ma. Zenaida Fernandez, M.D., Zamboanga City, The Philippines, and Edward G. Nedwicki, M.D., Allen Park.

Page 36, *"Use of Cholesterol Kits,"* by Kenneth R. Wilcox, M.D., (Reprint from New England Journal of Medicine, Vol. 279, No. 18).

Page 37, *"Mammography and Xeroradiography,"* by John N. Wolfe, M.D., Detroit.

Page 39, *"Early Management of Facial Nerve Trauma,"* by Roger Boles, M.D., Ann Arbor.

Page 45, *"Treatment of Hypercalcemia,"* by Joseph J. Weiss, M.D., and Jose Yanez, M.D., both of Eloise.

Page 49, *"More Drugs Mean More Problems in Managing Diabetes Mellitus,"* by John B. Bryan, M.D., F.A.C.P., Royal Oak.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT
CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FIVE-WEEK PERIOD ENDING JANUARY 4, 1969

	1968 This 5-Week Period	1967 Same 5-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	37	44	354	1049
Whooping Cough	21	86	429	1074
Diphtheria	0	0	0	1
Mumps	549	2516	14655	18198
Scarlet Fever & Strep Sore Throat	981	1374	10101	13425
Tetanus	2	2	5	7
Poliomyelitis (Paralytic)	—	—	3	3
Hepatitis	238	141	2356	1934
Salmonellosis (Other than S. typhi)	37	37	614	587
Typhoid Fever (S. typhi)	1	0	1	8
Shigellosis	60	32	346	422
Aseptic Meningitis	13	10	265	94
Encephalitis	17	11	114	113
Meningococcic Meningitis	6	7	94	79
Influenzal Meningitis	4	5	64	59

	1968 This 4-Week Period	1967 Same 4-Week Period	1968 Total to 12/27/68	1967 Total Same Date
Tuberculosis	164	166	2664	2917
Syphilis	313	398	5332	5644
Gonorrhea	1445	1219	18213	17146

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

Abstract

The toxicity for mice of some lots of diphtheria and tetanus toxoids and pertussis vaccine combined (DTP), either $AlPO_4$ adsorbed or alum precipitated, was greater when "syringe-mixed" with inactivated poliomyelitis vaccine from a separate container than when injected alone. When the vaccines were injected intra-abdominally, separately, two hours apart, mortality was approximately equal to that obtained when the vaccines were "syringe-mixed." When poliomyelitis vaccine was injected subcutaneously and the DTP was injected intra-abdominally, mortality was approximately equal to that found when mice received triple vaccine alone. Users of these products are cautioned not to combine them in the field from separate containers because there is no way to assure their safety for use in man. This precaution does not apply to a quadrivalent product issued by the manufacturer in a single multi-compartment syringe.

Mouse Toxicity of Triple Vaccine (DTP) Mixed with Poliomyelitis Vaccine

By R. Y. Gottshall
G. R. Anderson
E. A. Nelson
K. R. Wilcox, M.D.
All of Lansing

On several occasions during the past few years we were informed that children had developed severe local and, in some instances, general reactions after injection of diphtheria and tetanus toxoids and pertussis vaccine combined, aluminum phosphate adsorbed (DTP), prepared by our laboratories. Investigation revealed that in some instances our DTP had been "syringe-mixed" before injection with a killed poliomyelitis vaccine (prepared by another manufacturer) in order to give the four vaccines in one rather than two injections. This method of combining DTP and poliomyelitis vaccines for a single injection in man was used prior to the introduction of quadrivalent vaccines (vaccines containing diphtheria and tetanus antigens, pertussis and poliomyelitis [DTP-P]).[1]

Experience in our laboratories in the preparation of this quadrivalent product has shown that the combined DTP-P vaccine may be much more toxic for mice than any of the single antigens that were used to make the combined product. The toxicity occasionally found with lots of DTP is usually due to the pertussis component, and the addition of certain lots of inactivated polymyelitis vaccine potentiates the toxicity of the pertussis component. In our manufacturing process for quadrivalent vaccine, experience has dictated that the four antigens must be combined in a pilot lot and tested for toxicity in mice to determine whether the components are suitable for combination in production lot size.

With the knowledge that our DTP vaccines were being syringe-mixed with inactivated polio-

The four co-authors are all associated with the State of Michigan Department of Public Health Bureau of Laboratories. Doctor Wilcox is Associate Director of Laboratory Services and Chief of the Bureau of Laboratories.

myelitis vaccine prior to injection in man, we felt it essential to confirm and document the potential incompatibility of mixtures of DTP and poliomyelitis vaccine. The results of these investigations are reported in this paper.

Materials and Methods

Eight lots of diphtheria and tetanus toxoids and pertussis vaccine combined (DTP) were selected for syringe-mixing with poliomyelitis vaccine; seven of these lots were aluminum phosphate adsorbed and one lot was alum precipitated. Four of the aluminum phosphate adsorbed lots were prepared in our laboratories while the alum precipitated vaccine and three of the aluminum phosphate adsorbed vaccines were prepared by commercial manufacturers and purchased from drug stores. The single human dose of all of the DTP vaccines was 0.5 ml. Three different lots of inactivated poliomyelitis vaccine were obtained from commercial sources; two of these three lots of vaccine were prepared by one manufacturer. All of the poliomyelitis vaccines and the DTP vaccines purchased from drug stores were licensed by the Division of Biologics Standards of the National Institutes of Health (NIH). Equal volumes of DTP and poliomyelitis vaccine were drawn into a 2 ml. syringe and mixed in the syringe.

Toxicity tests in mice were performed according to the recommendations of the National Institutes of Health (Minimum Requirements for Pertussis Vaccine, May, 1953 and the revision of August, 1961) except that some tests were terminated on the sixth day after injection. The Webster strain of Swiss mice, weighing 14-16 gm, was used in all tests. Either 20 or 40 mice were injected intra-abdominally with each lot of DTP vaccine and 20 mice with each mixture of DTP vaccine and poliomyelitis vaccine. The single poliomyelitis vaccines were injected into 10 mice. For controls, a 0.9% solution of sodium chloride (NaCl) was injected into 10 male and 10 female mice each time a test was performed. Each mouse was weighed just before the intra-abdominal injection of vaccines or saline.

The volume and type of vaccine injected into each mouse consisted of either (1) 0.25 ml of DTP vaccine mixed with 0.25 ml of 0.9% NaCl, (2) 0.25 ml of DTP vaccine mixed with 0.25 ml of poliomyelitis vaccine, or (3) 0.25 ml of poliomyelitis vaccine.

All of the mice were examined daily while on test and the survivors weighed at three days and at six or seven days after administration of the vaccines or saline solution. Food and water were available during the entire test period. Vaccines are considered to be low in toxicity if the average gain in weight of survivors at the end of the test period was 3.0 gm or more and the mortality was not greater than five per cent.

Results and Discussion

In all of the tests the mice gained more than 3.0 gm in weight by the sixth day after injection of vaccine; this met one requirement of the test specifications. While the relationship is not absolute, in general, in those groups in which some mice died, the survivors gained the least weight. There was no mortality with four of the eight DTP vaccines when injected without poliomyelitis vaccine; with two, the mortality was 2.5%; with one, 5%. Only one sample of DTP vaccine (**Lot E, Table 1**) failed to pass the toxicity test. The manufacturer kindly furnished us directly with a 20 ml sample of this lot for repeat testing since it was impossible to obtain another supply on the market. In these repeat tests (not given in the Table) 30 mice were injected. One of these died (3.3% mortality) and the average gain in weight of the survivors seven days after injection of vaccine was 3.8 gm. Of 30 control mice injected with 0.5 ml of 0.9% sodium chloride solution none died and the average weight gain was 6.2 gm. (The test requirement is that the mortality not exceed 5%).

There was no toxicity shown by the three poliomyelitis vaccines given separately. The toxicity in mice of seven of eight of the DTP vaccines was potentiated after combination with poliomyelitis vaccine. Six of eight lots of DTP failed the mouse toxicity test after syringe-mixing with poliomyelitis vaccine #1; three of eight lots failed the toxicity test after syringe-mixing with poliomyelitis vaccine #2. By contrast, only one lot of DTP was found unacceptable after combination with poliomyelitis vaccine #3. Poliomyelitis vaccines #1 and #2 were prepared by the same manufacturer. DTP vaccine, Lot B, was extremely stable as evidenced by the fact that the toxicity test data of this material were not altered by syringe-mixing with any of the three poliomyelitis vaccines. Two DTP vaccines showing a low order of toxicity prior to combinaton were found to be compatible with all poliomyelitis vaccines tested.

When 0.25 ml of poliomyelitis vaccine was injected intra-abdominally in mice two hours before injection of one of the DTP vaccines, Lot C, the mortality was 20% with poliomyelitis vaccine #1, and 10% with poliomyelitis vaccine #2 (**Table 2**). This is approximately the same mortality as when these vaccines were "syringe-mixed" (**Table 1**). However, when the poliomyelitis vaccine was injected subcutaneously, and the DTP vaccine intra-abdominally, the mortality was approximately the same as when the DTP was injected alone. These data suggest that poliomyelitis vaccine must come

TABLE 1. — TOXICITY FOR MICE OF DTP ALONE AND WHEN MIXED WITH POLIOMYELITIS VACCINES

Lot of DTP	Mortality; No. of Mice Injected and Wt. Gain (gm)	Vaccine Injected			
		DTP Only	DTP Mixed with Poliomyelitis Vaccine		
			#1	#2	#3
A	D/n*	1/40	4/20	1/20	0/20
	% mortality	2.5	20	5	0
	Av. wt. gain	4.4	4.2	5.2	4.0
B	D/n	0/20	0/20	0/20	0/20
	% mortality	0	0	0	0
	Av. wt. gain	6.6	6.0	7.2	7.1
C	D/n	1/40	3/20	4/20	0/20
	% mortality	2.5	15	20	0
	Av. wt. gain	4.9	4.1	3.9	5.9
D	D/n	0/20	3/20	2/20	0/20
	% mortality	0	15	10	0
	Av. wt. gain	3.7	3.8	4.4	5.7
E	D/n	2/20†	3/20†	0/20†	—
	% mortality	10	15	0	—
	Av. wt. gain	4.1	3.7	3.5	—
F	D/n	0/20†	3/20†	1/20‡	0/20†
	% mortality	0	15	5	0
	Av. wt. gain	4.5	3.2	3.5	4.0
G	D/n	0/20	1/20†	0/20‡	0/20†
	% mortality	0	5	0	0
	Av. wt. gain	6.1	4.0	4.0	4.8
H	D/n	1/20	2/20	2/20	4/20
	% mortality	5	10	10	20
	Av. wt. gain	3.5	3.9	3.7	3.5
	D/n		0/10	0/10	0/10
Polio Vaccine Only	% mortality		0	0	0
	Av. wt. gain		5.4	5.3	5.0

Controls — Injected with 0.5 ml of 0.9% sodium chloride solution.
One of 80 mice died; average gain in weight, 6.1 gm.

* Died/number injected.

† Ten of these mice released from test 6 days after injection.

‡ All of these mice released from test 6 days after injection.

TABLE 2. — TOXICITY OF DTP AND POLIMYELITIS VACCINES WHEN INJECTED SEPARATELY AND AT DIFFERENT SITES

Lot of DTP	Injection Schedule	Polio Vaccine No.	Toxicity Test Results		
			D/n*	Per cent Mortality	Av. gain in weight gms
	0.25 ml Polio Vaccine intra-abdominally	1	4/20	20	4.3
	followed two hours later by 0.25 cc	2	2/20	10	4.0
C	DTP intra-abdominally 0.25 ml Polio Vaccine subcutaneously followed two hours later by 0.25 cc DTP intra-abdominally	1	1/40	2.5	5.4

* Died/number

in direct contact with DTP *in vitro* or *in vivo* in order to potentiate the toxicity of pertussis.

In all of these tests with DTP and mixtures of DTP and poliomyelitis vaccine, the mouse test was used as the index of toxicity of the vaccine. While the mouse toxicity test may not be universally accepted as a guide to toxicity in human subjects, it does measure the relative toxicity of these vaccines and a mixture low in toxicity for mice would certainly be preferable for use in man. We have demonstrated that the toxicity in mice of DTP vaccines may be enhanced following combination with poliomyelitis vaccine. Nearly one-half (10 of 23) of the DTP-P mixtures we prepared by mixing in syringes would not have passed the requirements for toxicity of the quadrivalent product as recommended by the National Institutes of Health for release under license.

The toxicity-enhancing potential for DTP vaccine was found to vary among individual lots of poliomyelitis vaccine. At the present time there does not appear to be any means whereby a physician could syringe-mix poliomyelitis vaccine and DTP vaccine in the field and be certain that the mixture would be safe for injection in man. From these data we can conclude that separate poliomyelitis and DTP vaccines should not be syringe-mixed immediately prior to injection in man unless all of the components have been previously tested in combination and found compatible. In fact, sound immunization practice should preclude the combination in the field of any vaccines that have not been proven compatible by the manufacturer after extensive testing in the laboratory.

References

1. Batson, R., Christie, A., Mazur, B., and Barrick, J. H. Response of young infants to poliomyelitis vaccine given separately and combined with other antigens. *Pediatrics 21*:1-6, Jan. 1958.

Massive Intra-articular Injection Of Methylprednisolone without Harmful Side Effect

BY J. C. BRENEMAN, M.D.
GALESBURG

(3620 mgm. of methylprednisolone injected into the right knee joint over a period of 56 months)

This case is presented as a degenerative osteoarthritis of the right knee. Over the course of 56 months 3620 mgm. of methylprednisolone were injected intra-articularly. At no time over the nearly five years of treatment was there evidence of systemic side effects from absorption from the serosal surface. Neither was there evidence of Charcot type joint deterioration as a result of the anti-inflammatory and anti-pain-perceptive effect of the methylprednisolone. Regional osteoporosis was no more marked than one would expect of the ordinary osteoarthritis in a person of this age.

This obese 73-year old white female was first seen July 8, 1963. Her complaint was swelling, arthritis and pain in the right knee. Under local anesthesia, a specimen of joint fluid was obtained. Forty milligrams of methylprednisolone* were instilled into the joint. This procedure was

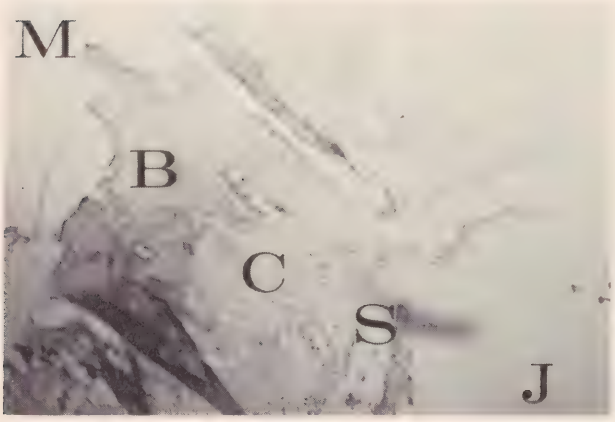


Fig. 1
Low power photo showing degenerative arthritis.

*As DepoMedrol, the Upjohn Company, Kalamazoo, Michigan

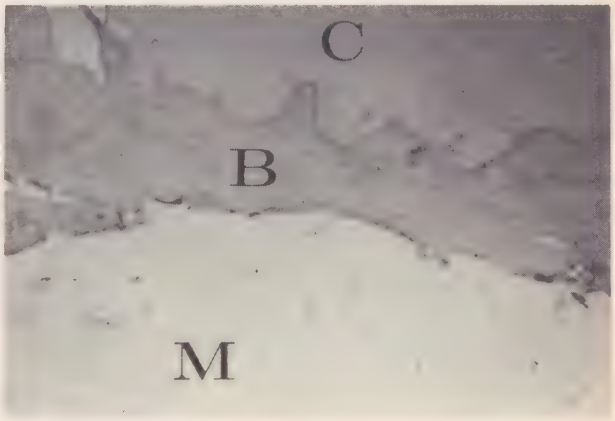


Fig. 2
Higher power photo of joint cross section.

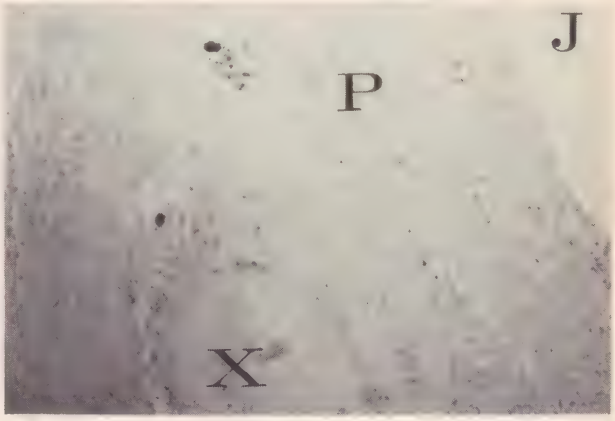


Fig. 3
High power photo showing pannus of abnormal synovial tissue. Remarkable dirth of inflammation is probably due to steroid effect.

X- Area of amorphous material probably represents tissue reaction to methylprednisolone crystals.

Key to Post Mortem Biopsies of Right Knee Joint.

B – Bone	M – Marrow
C – Cartilage	P – Pannus
J – Joint Space	S – Synovia

repeated two days later with marked symptomatic relief. The joint fluid removed was found to have a uric acid level of 4.9mg%. This patient's serum uric acid level was 5.7mg%. The RA latex agglutination was negative. Sedimentation rate was 22mm/hr. Hemoglobin was 14.8 grams, white blood count was 6,980, N-64 (0-0-18-46), L-34, M-2. Hematocrit was 46%.

Over the course of the succeeding 56 months injections in increasing doses and in decreasing increments of time were given into this joint until a total of 3.62 grams had been given. On April 8, 1968, the patient died suddenly of a pulmonary embolus. Her age at the time of death was 78 years. Post-mortem sections of the knee joint (**Figures 1, 2 & 3**) showed no unusual gross or microscopic evidence of toxic or noxious effect from the huge amount of methylprednisolone that had been instilled into the knee joint. Throughout the five years there was no evidence of systemic Cushing's type changes.

On the basis of this case it is apparent that huge doses of methylprednisolone can be given intra-articularly without fear of serious side effect.

Table showing dates of injections and the amounts of methylprednisolone given intra-articularly.

7- 8-63	40mgm
8-26-63	40mgm
9-23-63	80mgm
10-28-63	80mgm
11-18-63	80mgm
12-23-63	80mgm
Total 1963	400mgm
3-16-64	80mgm
7- 7-64	80mgm
7-27-64	80mgm
9-14-64	80mgm
10-27-64	80mgm
11-30-64	80mgm
12-31-64	80mgm
Total 1964	560mgm
2- 3-65	80mgm
3-29-65	80mgm
5-14-68	160mgm
8- 2-65	160mgm
9-27-65	80mgm
10-25-65	80mgm
12-16-65	80mgm
Total 1965	720mgm
1-28-66	80mgm
3-14-66	80mgm
5-25-66	80mgm
7-20-66	80mgm
8-22-66	120mgm
11-17-66	120mgm
Total 1966	560mgm
1-23-67	120mgm
3-13-67	120mgm
4-22-67	60mgm
5-20-67	40mgm
6-15-67	120mgm
7- 3-67	60mgm
7-10-67	20mgm
7-21-67	80mgm
9- 9-67	120mgm
10- 2-67	80mgm
11- 6-67	80mgm
11-30-67	80mgm
12-28-67	80mgm
Total 1967	1060mgm
1-18-68	80mgm
2-10-68	80mgm
2-26-68	80mgm
3-25-68	80mgm
Total 1968	320mgm
1963	400mgm
1964	560mgm
1965	720mgm
1966	560mgm
1967	1060mgm
1968	320mgm
Total	3,620mgm

"It's stimulating . . . mind expanding . . . safer to use than alcohol. It's the 'IN' thing — the hula-hoop of the jet generation, and as much a part of growing up as smoking corn silk behind the back fence.

"Such are the myths concerning marijuana . . . myths that lull thousands of young people into 'experimenting' with the noxious weed.

"The facts are otherwise. Marijuana is an intoxicating, psychologically addicting, mind-muddling drug. Its use can lead to slavish physical addiction to other drugs.

"The human brain, after all, is made for thinking . . . not fumigating. It's hardly a tinker-toy for experimenting with drugs."



Michigan Physicians Direct Information On Drug Abuse to Youth, Parents

BY JUDITH MARR, MANAGING EDITOR

The quoted passage above is a clear, straight-shooting message from the AMA — part of an educational campaign about drug abuse being carried on by the medical profession.

Michigan Physicians Separate Myth From Fact

In Michigan, the campaign is being led by dedicated local medical personnel, individually and in county societies, who are doing their best to separate myth from fact in the minds of adults and youth caught up in the problem of drug abuse.

Their stories follow below, emphasized by excerpts from a news release issued in December by Robert J. Mason, M.D., Birmingham, president-elect of the Michigan State Medical Society. Doctor Mason, in the MSMS release, said parents must face up to the problems of drug abuse by youngsters rather than try to ignore them and they should become more active in community efforts to reduce drug abuse.

He told Michigan adults that the AMA has issued the strongest indictment of marijuana ever made by medical authorities and said, it should not be used because (1) it is illegal, (2) it can and often does lead to stronger and more dangerous drugs, (3) there is danger of personal injury to the user and others around while the user is "high" and (4) the drug user will not fulfill his ambitions, is often unemployed, and turns to crime.

MD-Led Jackson Council Has Comprehensive Plan

The activities of a Jackson citizens' panel organized to fight drug abuse are setting an example of what can be done under M.D. leadership to combat a health problem.

In just six months, the Jackson Area Drug Abuse Council, led by Robert E. Medlar, M.D., has pinpointed the local problem, held a community-wide Drug Forum, and published a brochure. It has also organized a Speakers Bureau which has sent members of the Council to local organizations on over 25 occasions to discuss the drug problem and possible solutions.

"That's just a beginning," says Doctor Medlar of his ambitious group.

The voluntary Council wishes to provide education on drug abuse for the adult community, and, even more, to insert studies on the subject into the regular Jackson public and parochial school curriculums.

"We hope by next fall to bring these plans into being," says Dr. Medlar. The Council also plans to repeat its public seminar in a year.

The Council was organized when Doctor Medlar assembled nine community representatives in his



Facing the public at an open forum on drug abuse staged in Jackson in the fall were, left to right, Gerald Lang, coordinator of institutional resources for the Jackson County Intermediate School District; Robert Medlar, M.D., chairman of the Jackson Area Drug Abuse Council; Patrick Donlon, M.D., Detroit psychologist; Sgt. John Grzesek, of the narcotics division of the Jackson City Police Department; Lt. Burton Miller, chief of the narcotics division, Cleveland Police Department, and Howard Thompson, coordinator of physical education and health services for the Jackson Public Schools.

living room Sept. 4, for a discussion on drug use and abuse.

One of those present was Lt. Harold E. Rutledge, head of the Jackson Police Department's Youth Bureau, whose frank opening remarks startled the group.

"Drug and narcotic cases are increasing monthly in Jackson," said Lt. Rutledge, "and marijuana is locally grown." Jackson youth are processing their own marijuana, he continued, and that means someone is showing them how.

The police believe drug abuse in Jackson is climbing right along with the crime rate.

Doctor Medlar, who is also president of the Jackson Public School Board of Education, remarked, "Now we know we have a problem. It has been hearsay up to now."

His opinion was shared by other members of the original group, among them Clifford Keeler, M.D.; John McLaughlin, M.D., president of the Jackson County Medical Society; representatives from the Jackson Public Schools, and a pharmacist. The group decided to concentrate its study on the local use of LSD, glue sniffing, marijuana, bennies, and certain cough syrups containing codeine.

The public forum Oct. 20 opened an intensive effort by the new Council to educate adults of the community and gain their support. The speakers bureau was formed, the council contacted local organizations and worked through the news media.

The Council has since added two attorneys, another representative from the Police Department, a Jackson Community College teacher, and



John McLaughlin, M.D., Jackson Area Drug Abuse Council's Speakers Bureau discusses drug abuse with a high school class.

(Jackson Citizens Patriot Photos by Steve McCortie)

a Juvenile Court Judge, among others. Richard van Schoick, M.D., a pediatrician, will soon join, also.

"We have no way yet of measuring our effect," says Doctor Medlar. "But we believe there are a great many more persons who are aware that this is a problem locally."

Radio, Pamphlets, Talks Used in Muskegon Drive

During Community Health Week in November, the Muskegon County Medical Society:

(1) sponsored approximately 25 lectures by local physicians before junior and senior high school student bodies;

(2) developed radio programs over local stations airing short talks by physicians, followed by questions and answers.

(3) made 15,000 AMA-prepared pamphlets available to County Society Auxiliary members who passed them out to junior and senior high students throughout the Greater Muskegon area.

The activities were part of a drug abuse education program aimed at youth and their parents. And the education is continuing. The doctors who spoke before the student groups are now sought as speakers for PTA meetings.

The Muskegon Society has previously conducted education campaigns on venereal disease, alcohol and smoking health problems. One year the doctors gave a total of 70 lectures before school assemblies, and the succeeding opportunities to speak to PTA's doubled that figure.

Bernard L. Wildgen, M.D., chairman of the county society's School Advisory Committee which has charge of the educational campaigns, has asked the county society to underwrite the purchase of an additional 1,000 copies of each of the AMA drug abuse pamphlets for distribution at Muskegon Community College, which was not included in the original campaign.

Doctor Wildgen plans to make sure the pamphlets are "judiciously passed out" and "not frittered away" at the college.

That was the pattern in the earlier dissemination of educational materials in high schools. There, members of the National Honor Society and science clubs, for insance, were called on.

Preparatory to scheduling the speeches, the committee wrote the schools, informing them of Community Health Week and asking if they would be interested in setting aside time for the physicians to speak to general assemblies of students.

"The response was good from the schools and we had excellent cooperation from our doctors," says Doctor Wildgen.

Doctor Wildgen and his committee found that the combination of speeches and distribution of educational materials "comprised an excellent program from the point of bringing the students up to date on drug abuse."



Educator Gerald Lang, left, and Sgt. John Grzesek take Jackson Drug Abuse Council's display kit to school classes.

Oakland County Society Examines Drug Abuse

The Oakland County Medical Society has also been concerned with the problem of drug abuse and recently expanded its December meeting, traditionally reserved for elections, to include a talk on the subject.

Speakers were L. Jerome Fink, M.D., a member of the society, and Jerry St. Souver, of the Oakland County Prosecutor's Office, phychiatrist and chairman of the Oakland Society's Press and Public Relations Committee.

Their topic was "Drug Abuse — Oakland County's Latest Problem," and the men illustrated their remarks with the film, "LSD — Insight or Insanity."

WSU Pharmacy Students Appearing at High Schools

Twenty WSU pharmacy students are going into high schools in the metropolitan area to explain the uses, misuses and abuse of drugs.

WSU Pharmacy Dean Martin Barr advocates that "drug respect" should be taught at the kindergarten level rather than waiting until the upper grades.

Raskin Probes User's Reasons; Calls For Community Drug Control

The following passage is excerpted from a speech prepared for presentation to the Detroit Common Council Jan. 13 by Herbert A. Raskin, M.D., chairman of the MSMS Committee on Alcohol and Drug Dependence and member of the Detroit Mayor's Committee for the Rehabilitation of Narcotic Addicts.

". . . perhaps the most insidious long term effect (on the drug user) of all, and of paramount significance, is the habit of "tuning out" on reality when reality seems to offer some discomfort — a side-stepping of problems and difficulties which leads to a regressed and minimally functioning person.

"This constitutes the essence of drug dependence, psychological dependence upon the drug, a reaching out for a substance to do the decision-making, to literally do his living for him. It is a kind of reliance upon something outside of oneself to be seen nowhere else in human functioning.

"This becomes particularly important among persons of teenage and early adult age groups. It is at this time of growth and development when, hopefully, the individual is beginning to sharpen up his reality living experiences.

"The drug dependent person constitutes a particularly unique type of problem to himself and to society. Drug dependence is a medical syndrome, a relapsing complex invariably reflecting some form of underlying emotional disturbance. It is part of a symptom complex representing a mode of adaptation, perhaps the sole adjustive mechanism to living problems the person has available at the moment.

"He manifests his disturbance in great part through his craving for and his particular relationship to the drug substance. It is a kind of last-grasping toward something that to him will forestall the horror of inevitable disintegration of self, of psychic disorganization that spells the doom of total helplessness. He has found something that he knows will give him relief from unbearable tensions and anxieties. Even a strong wish to be rid of the drug is complicated by an even stronger fear of his real ability to function without it. He is beset with an insidious, inexorable helplessness to deal with his state of dependence by himself. His social behavior antagonizes us; his state of abject dependence repels us. But yet it is essential that he be shown the same kindness and compassion as would be shown to any person suffering from any illness, physical or mental.

"Our Community problem of drug abuse and drug dependence must be approached simultaneously along three lines of action: (1) our educational facilities, (2) law enforcement, and (3) adequate and proper psychological growth and development of our children.

"It is the responsibility of the fields of medicine, psychology, law, law enforcement, judiciary, sociology, social work and ancillary governmental and voluntary groups to meet and to work with any individual beset with this problem. It remains, though, the ultimate responsibility of each citizen and his governmental representatives in any community where such problems exist to demand the provision and financing of adequate facilities.

"The extent of the problem in our major metropolitan areas dictates the development of community control programs.

"The community must become cognizant of the severe emotional sickness and the helplessness of the drug dependent person. The community must recognize his total inability to provide help for himself with his problem of drug dependence and his incapacity to cope with the myriad of unpleasant realities of routine living with or without the drug. The community dare no longer disregard its own responsibility toward the care of its own problem of drug dependence, and, perhaps, its own responsibility in the creation of this problem. It is a financial burden, a costly one. But so is its cost in terms of self-degradation, family disintegration and social disorganization."



SOCIO - ECONOMIC

Michigan Per-Capita Income 2nd Highest in Midwest

Gains in personal income in Michigan and the Midwest climbed about 8 percent in 1968, half again more than last year but less than the gain for the nation which reflected very strong advances in the South and the West.

Income growth in the Midwest has been slower than the nation since the early 1950s.

"Nevertheless, in terms of actual per-capita income, the Midwest stacks up very well," reports the Federal Reserve Bank of Chicago.

Michigan and Illinois, the most capital-intensive states in the Midwest, will run ahead of national figures for 1968. The national per-capita income was $3,374, below Michigan with its $3,598. Illinois is the only Seventh Federal Reserve District state to top Michigan with its $3,985.

In recent years, Ann Arbor paced the Midwest cities in rate of growth in per-capita income. Between 1959 and 1966, total personal income grew in the nation at an average annual rate of 6.3 percent while the average annual gain for Ann Arbor was 8.6 percent.

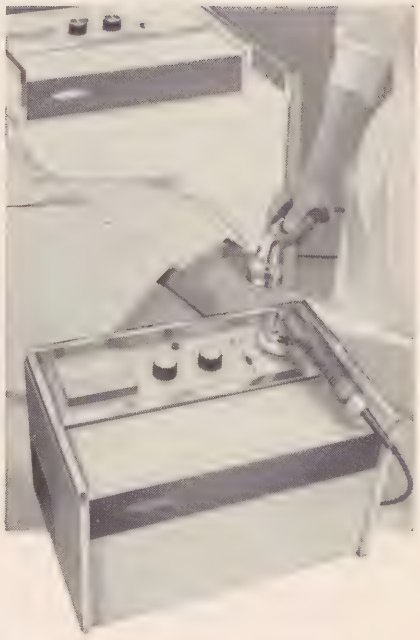
HOSPITALS ADVISED ON LABOR RELATIONS

At least some employees have been unionized at a total of 65 Michigan hospitals, was the report at a fall workshop in Hospital Labor Relations in Traverse City.

Charles A. Rogers, personnel counsel for the MHA, set the pace of the meeting when he delivered that fact.

Speakers at the workshop constantly reiterated that hospitals must be prepared and in order to do that must have their own houses in order with good personnel policies and practices.

Administrators were also advised not to attempt to go it alone but to get the assistance of a competent labor relations counsel when dealing with labor.



Another step forward in Ultrasonics
The Burdick UT/420 Continuous or Pulsed Ultrasound



Burdick introduces its newly designed UT/420 Ultrasound! Handsomely styled, the new UT/420 produces a combination of thermal, mechanical, and chemical effects in tissue not possible with any other modality. Selection of **continuous** or **pulsed** energy offers flexibility of treatment—pulsed ultrasound permits increased mechanical effects at higher intensities without pain.
Ask your Burdick dealer about the UT/420 (he has an **Ultrasound Dosage Chart** for you as an aid to more effective treatment)—or write us.

THE BURDICK CORPORATION
MILTON, WISCONSIN 53563

Medical Arts Supply
311 State, S.E. Grand Rapids, Mich.
Phone 616 459-9413

Explains 10 Goals of New AMA Division On Public Affairs to Better Meet Challenges

BY JOE D. MILLER, DIRECTOR,
AMA DIVISION ON PUBLIC AFFAIRS

Medicine's problems are complex and pressing: The shortage of physicians and other members of the health team in relation to the multiplied demand; the gap between demand for hospital and nursing home services and their availability; the rising costs of health care.

These and other problems must ultimately be solved, either by the private sector or — by default — government.

The critical element in medicine's search for solutions is time. Given enough time, most of the answers can be found by the private sector. Given insufficient time, government is likely to act precipitately in response to public pressure.

FOR THE FORESEEABLE FUTURE, changes in medical science and practice will affect the environment in which they are made. And at the same time, that environment will influence the manner in which medical science and practice function.

The AMA, as the organization that unifies the nation's physicians, must prepare to meet present and future health needs in the United States; direct the present trends to the degree legally feasible; and argue its case persuasively with the government and the public.

Thus no aspect of the AMA's planning, operation or activity is independent of what the AMA is able to accomplish in public affairs. This is true even of the scientific and medical areas in which the AMA functions so competently: the ability to perform capably in these areas requires the freedom in which to do it.

A NEW APPROACH IS therefore required, along with a new organizational structure with which to execute it.

The creation of a new Division of Public Affairs is a first step in that direction. The move is practical and logical. It will result in better staff coordination, administrative efficiency and economical operation. When fully operative, the new Division of Public Affairs will be capable not only of providing better legislative and socio-economic services to the constituent and component medical societies, but of coordinating them better from the management to the field levels.

One definition of public affairs is "a systematic effort to safeguard an organization's rights and fulfill its responsibilities to the community while encouraging individual members of the organization to safeguard their own rights and fulfill their own responsibilities."

APPLYING THAT DEFINITION, then, the new Division of Public Affairs has adopted 10 goals:

1. To help inform the profession, public and legislators of the problems facing medicine.

2. To foster a better understanding of government on the part of physicians and their wives and stimulate their activity in civic and political affairs.

3. To help medicine amplify its voice in community, state and national affairs.

4. To disseminate information of interest to legislators and maintain a practical legislative liaison.

5. To encourage physicians and their wives to join the PAC movement, and to become active in the political party of their choice.

6. To serve the component and constituent medical societies effectively and frequently with legislative and political information.

7. To provide non-partisan political education programs for individuals and medical societies.

8. To undertake such objective, educational research as may be helpful.

9. To furnish close liaison between the AMA and the component and constituent societies to foster communications on public affairs.

10. To maintain contact and improve coordination with other public affairs movements of a non-medical nature.

In the performance of these functions, the new Division of Public Affairs will work closely with the other divisions of the AMA and with appropriate Councils, and will routinely maintain liaison with AMPAC and State PACs.

AMPAC WILL MAINTAIN its individual entity as an organization separate from the AMA and governed by its own Board of Directors.

The reorganization produces immediate benefits to both the AMA and AMPAC, and those benefits will be multiplied in the years ahead as improved staff coordination, greater administrative efficiency, better liaison and enhanced services to the component and constituent societies pay dividends to organized medicine at every level of its participation in public affairs.

Engelke, in Letter to AMA, Evaluates Weaknesses of New Health Laws

(Editor's Note: The following is a letter from Otto K. Engelke, M.D., Chairman of the MSMS Committee on Legal Affairs, to Dwight L. Wilbur, M.D., President of the AMA, expressing Doctor Engelke's views on two new laws.)

23 December 1968
Dwight L. Wilbur, M.D., President
American Medical Society
655 Sutter Street
San Francisco, California 94102

Dear Dwight:

A thousand apologies for this slight delay in my report to you on Public Law 89-749 (Comprehensive Health Planning Act) and its subsequent amendment Public Law 90-174 (Partnership for Health amendments). I will try to keep this all as brief as possible and this will not be easy.

It is my impression that both of these pieces of legislation are of poor quality and unless they are changed will create many problems in the administration of health care to the American people. Their inception, as you know, was originally based upon a laudable desire of the state and territorial health officers and other health officials for a switch from categorical federal aid programs to a plan which would allow states to accept federal dollars which were not earmarked and which could be used at the state and local level to meet locally determined needs.

It has also been my feeling that the original thrust was toward the allocation of such money for official health agency use and not toward funds covering the entire medical care as well as private and public health agency fields. Once the legislation was passed much of this original thinking, it seemed, had been lost.

As these two acts now stand I think they are the umbrella legislation which will transcend all other federal acts eventually and give complete federal legislative control over all personal health care as well as public and private agency service.

To those of us who have worked with state and federal legislative language this appears to be quite clear. In every section of importance there is a statement to the effect that planning, programming, policies, procedures, fiscal accounting, etc., require the final approval of the Secretary of Health, Education and Welfare at Washington. People who are busy working in this field for the first time seem to ignore this fact.

AMA President Replies:

Dear Doctor Engelke:

I much appreciated the excellent letter you sent me on December 23 on your ideas concerning the implications of 87-749 and 90-174, and the potential sections of these laws which obviously should be repealed or amended.

You obviously have given great thought to this matter and I am going to take the privilege of passing your thoughts on to members of the Council on Legislative Activities and the staff of the AMA.

With many thanks and best wishes, I am

Dwight L. Wilbur, M.D.,
President, AMA

Except for a sentence or two in Public Law 90-174 of the 90th Congress, specifically Section 3 (b) (2), it is difficult to find any reference to local governmental units anywhere in these two bills. Local boards of health, state boards of health, state health councils, and other responsible policy making bodies, all seem to have been overlooked.

In a state like Michigan these groups are responsible for the administration of many millions of dollars worth of official public health agency activities at the local, county and city level alone. State, private, and public agency appropriations for mental health, tuberculosis control, services to the medically indigent, water pollution control, waste disposal, food sanitation, private medical care, etc., are not included in this figure. Planning and services related to all of these funds would be placed ultimately in the control of the Department of Health, Education and Welfare under Public Law 89-749 and 90-174.

I suggest that you do a check of Section 2 (a) - (2) of Public Law 90-174 and read it carefully as an example of the language in these bills. The underlining is mine. It follows and amends Public Law 89-749, Section 314 (a) (2).

(2) Subsection (a) (2) of such section is amended by redesignating subparagraphs (I) and (J) as subparagraphs (J) and (K), respectively, and by inserting after subparagraph (H) the following new paragraph:

"(I) effective July 1, 1968, (i) provide for assisting each health care facility in the State to develop a program for capital expenditures for replacement, modernization, and expansion which is consistent with an overall State plan developed in accordance with criteria established by the Secretary after consultation with the State which will meet the needs of the State for health care facilities, equipment, and services without duplication and otherwise in the most efficient and economical manner, and (ii) provide that the State agency furnishing such assistance will periodically review the program [developed pursuant to clause (i)] of each health care facility in the State and recommend appropriate modification thereof;".

Added to the bulk of the legislation included in 89-749 nothing more is needed to give the Department of Health, Education and Welfare complete control over our health care, our environment, and almost everything else related thereto.

Another major objection to this bill is that while it appears to emphasize planning originating and maintained at the local level it is actually "planning" at the federal level superimposed upon localities with plenty of federal rules and regulations to see that everyone stays in line. All planning procedures, etc., must be approved by the Secretary of Health, Education and Welfare.

In Michigan, as a concrete example of this, we have received word from our governor's office that federal regulations require that they designate 12 planning regions for this state and they apparently have done so without consulting any of the regions involved or the medical profession.

There seems to be some feeling that effective planning has never gone on before in these United States and that in order to be effective the new planning must be run pretty much as a government monopoly with the rules all coming from Washington. Many of us do not believe monopolies are any better in government than they are in private enterprise.

With the details that go along with this legislation, the power struggle involved in seeking the local planning "authority" is something to behold in this state and I imagine in others. It is the feeling of many of us that this power struggle will not be resolved for many years and will leave scars that will be difficult to heal even if these bills become really operative. In the meantime, many worthy health programs will wither for lack of attention.

Of course, in the planning, programming, policy making and administrative processes outlined in the bills one finds a mandate for the establishment of an entirely new bureaucracy at the local, state, regional and federal level. To this bureaucracy one can add the new bureaucracy being established in many states to administer the Federal Heart, Cancer and Stroke Program which will eventually be a subsidiary of Comprehensive Health Planning. To this, of course, can also be added the bureaucracies of many other similar federally spawned programs such as OEO, HUD and others all heavily involved in health both personal and public.

I think the principal products of these efforts to shift the authority of our current local and state operations to the Federal Comprehensive Health Planning bureaucracy will be rampant confusion, power struggles at all levels, and federal dictation.

During the planning period and thereafter Public Law 89-749 proceeds to make millions of dollars available to private as well as public health agencies and almost any other type of organization.

While at first this windfall of federal money may seem very attractive to private health agencies, those of us who have lived with federal dollars for several decades would like to remind the private health agency people that with federal dollars come federal controls. It has taken approximately 20-25 years for this to occur in the official public health field.

I personally wonder how long it will take for federal controls to be established over the private health agencies who are seeking and spending federal health dollars. Of course, the principal reason for the existence of private health agencies has been their independence and freedom from government interference. Their flexibility in programming and research has also been important.

It is my belief and the belief of some others that Comprehensive Health Planning dollars will be irresistible to agency executives as well as boards of directors. Even where these moneys are but a small part of an agency budget the control which follows them will be decisive.

Some of us think it is very significant that some medical societies are operating with federal dollars in some "direct service" and "research" or "demonstration" programs.

In other words, it is my belief that "Comprehensive Health Planning" and "Partnership in Health" constitute a major threat to the independence of health agencies as well as some medical societies in this nation and almost surely will make them captives of the federal establishment.

We are now going through a period which corresponds to the honeymoon. The facts of life, many of us feel, will come later. At least this has been the pattern in official public health where we are now being forced to dance to the federal tune in many areas even where the percentages of

federal dollars are still relatively unimportant. Similar federal domination would certainly come to conservation, education, agriculture, law enforcement and other local governmental functions if they are subverted by legislation with titles as seductive as "Comprehensive Health Planning" and "Partnership for Health."

I have been told by people that I am unnecessarily concerned about federal controls and I have asked these people if they have actually read the legislation. In nearly all cases they have not. They have read someone's "interpretation" of the law.

Anyone who will take time to read the legislation itself will be impressed with some of the points that have been made in this correspondence.

I don't think it is enough, Dwight, to point to the defects in this legislation unless some suggestion is made as to what changes are in order.

Of course, ideally, both bills should be repealed but this would probably be as practical as trying to unscramble eggs. Certainly, our legal brains at the AMA and those doctors who serve on our committees that deal with national legislation could seek the repeal of sections like the one I quoted above from Public Law 90-174. Many of the references to the authority and controls of the Secretary of Health, Education and Welfare could be deleted or modified. Federal grants to private health agencies could be closely examined and perhaps phased out although this seems a rather remote possibility now.

I would think the problem important enough to charge a standing committee or a special committee of the AMA with the responsibility for producing amendments to this legislation which might save the day. We have to hurry if we are to accomplish this objective.

Very truly yours,

Otto K. Engelke, M.D., Chairman
MSMS Committee on Legal Affairs

P.S. I have noticed one advantage in these pieces of legislation. Hopeless as they are and threatening as they are, they have at least directed the attention of many of the physicians of the United States to the problems of the entire community in which they live. This is true in spite of language in the bills which would seem to try to minimize the participation of the doctors and others most knowledgeable in health matters.

The role of the physician as a citizen is being stressed by organized medicine itself. This may be one redeeming feature of this whole mess.

INGRAM'S SERVICE DEPARTMENT

ALL FACTORY TRAINED MEN

We service Medical Equipment, Electrocardiographs, Basal Metabalors, Sterilizers, Autoclaves, Diathermy Outfits, Cutting Units, Ultra Violet Lamps, Hydro Therapy Units, Laboratory Equipment. ALL BURDICK, LIEBEL FLARSHEIM AND RITTER EQUIPMENT.

If you have any Service problems, please call us at TE 2-4444, ask for the SERVICE DEPARTMENT and we will gladly help in any way we can.

THE G. A. INGRAM COMPANY

4444 Woodward Avenue TEmple 2-4444 Detroit, Michigan 48201



C. Mark Vasu, M.D., Grand Rapids, prepares to leave for night's service with Grand Rapids Police Department's new emergency medical care unit.

Grand Rapids Leading the Way In Emergency Medical Care Programs

The problem of emergency medical care, particularly at the scene of highway accidents, is "an enormous problem," believes C. Mark Vasu, M.D., Grand Rapids.

"I think more doctors have got to get involved in solving the problem," says the Grand Rapids physician, who is chairman of the Kent County Medical Society's Emergency Medical Services Committee.

"Every year in the U.S. 10,000 to 15,000 persons are killed at the scene of an accident or en route to the hospital as a result of added injuries from poor care," says the doctor. "An additional 35,000 to 45,000 are permanently injured."

According to Doctor Vasu: "It is an established fact that policemen, firemen and ambulance personnel are involved in the first aid rescue work of emergency medical care almost every day. These men have advanced Red Cross training which in itself is good but lacking in some of the more refined principles of medical care that physicians feel are basic to the total approach to the victim. With this thought in mind, we simply feel that more doctors have got to become involved in solving this problem."

Doctor Vasu's committee is setting the example.

For the last three years, they have guided a large-scale emergency medical care training program in Grand Rapids. Doctor Vasu and other local physicians including cardiologists, obstetricians, pediatricians and neurosurgeons, teach advanced and up-to-date methods of first aid regularly to members of the city police and fire departments and the county sheriff's departments and ambulance personnel.

The program is given every two months from September to May with the summer optional, and usually includes one program of a demonstration type outdoors. So popular is the course that each session averages 200 participants, who come from all over the west state area, says Doctor Vasu.

But Doctor Vasu's efforts don't stop at the local level.

Prior to 1968 the State of Michigan had no ambulance ordinance. Doctor Vasu spent an entire day last Spring testifying before the Legislative Committee to the need for a state-wide ambulance ordinance. The ordinance — House Bill 3946 — will become law July 1.

However, it is "only a breakthrough, providing some kind of an ordinance," says Doctor Vasu. The ordinance requires only one man in the ambulance and "this is a ridiculous situation," he comments. "There are areas of concern regarding age restriction, training and equipment that are not well defined."

To rectify this problem, the Grand Rapids City Commission accepted recommendations by Doctor Vasu and his committee for a new ambulance ordinance in the city of Grand Rapids. It requires two men in each ambulance and both the driver and attendant have to be 21 years of age.

"But the real beauty of our ordinance," says Doctor Vasu, "is the amount of medical training required of all the ambulance attendants."

They must (1) complete the Red Cross Advanced First Aid Course, (2) work in an emergency room setting for first hand contact with the physician and patient, (3) take a brief course in emergency childbirth delivery and be present at a birth, and (4) take training in cardiac resuscitation, involving both mouth to mouth and cardiac massage techniques.

"Nowhere else in the U.S. is the fourth phase, involving both types of resuscitation, required of ambulance attendants," says Doctor Vasu.

In addition to sponsoring the ambulance ordinance and training programs for police, fire and ambulance personnel, the Kent County physicians two years ago formed "The Crash Squad," now a group of 15 doctors who volunteer for emergency medical calls at any hour of the day or night.

"But we were never called," says a disappointed Doctor Vasu. "And so we decided to press our involvement."

With the help of the Police and Fire Chiefs and the ambulance companies, a police emergency unit was started.

The innovative emergency unit, which has attracted much local and regional attention, is a red station wagon operated 24 hours a day by the police force and stocked with special equipment well within the requirements of the American College of Surgeons.

For 15 nights after it first began patrolling Grand Rapids streets in December, a Kent County Medical Society member travelled with it from 6 p.m. to 6 a.m. All types of calls were encountered — accidents, shootings, knifings, family squabbles and attempted suicide. For at least another year the doctors will ride with the unit during the same hours every Friday and Saturday nights when accidents are heaviest, says Doctor Vasu.

The purpose of the special unit is two-fold, explains the doctor. First, the doctor will be able to see first-hand the problems encountered at accident or crime scenes. Second, he can give the patrolman on-the-job training.

The emergency unit does not provide transportation from accident scene to hospital, however; the city's three ambulance services continue to do that.

"The emergency squad established a lot of enthusiasm among people here," says Doctor Vasu. "This is the second biggest county in the state and a lot of people are excited about the service — and so are the doctors and the police."

Indeed, local newspapers have carried editorials praising the squad and urging its support. Said the *Grand Rapids Press* after the inauguration of the new service, "The Medical Society's Emergency Medical Services Committee, headed by Doctor C. Mark Vasu, ought to receive a rousing cheer for what it is doing at its own expense to improve emergency medical services in the community."

The Trustees of the Grand Rapids Bar Association passed a resolution indicating their "enthusiastic support" of the program.

But effective as the emergency unit is, Doctor Vasu and his committee are still primarily interested in over-all emergency medical care.

"Through our efforts we have been able to involve all four facets of emergency medical care — first aid and rescue, communication between police, fire, ambulance and medical personnel, transportation and the emergency facility," says Doctor Vasu.

"Some of our colleagues have been astounded that we've been able to get so much cooperation between ambulance, police and fire department people," continues the doctor.

"But it's very simple," he says. "Together we must realize that we have a problem and decide to do something about it."

Efforts in the Grand Rapids area have been mighty and successful but they are not enough, he maintains.

"These things should be done on a state level," Doctor Vasu says. "We have to get all the counties in the state behind a program whereby doctors are more involved in personal and injury care."

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan — MU 5-8441

Edwin M. Williamson, M.D.
M. Leroy Barry, M.D.
Dan W. Everett, M.D.
Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN, TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330—8/6135

FOURTEENTH ANNUAL

MEDICLINICS

POSTGRADUATE MEDICAL

REFRESHER COURSE

MARCH 10-20, 1969

FORT LAUDERDALE, FLORIDA

Headquarters: Galt Ocean Mile Hotel

Sponsored by Florida Academy of General Practice and the North Broward General Hospital. Accepted for 32 hours of credit by the American Academy of General Practice.

Registration information:

MEDICLINICS

832 CENTRAL MEDICAL BUILDING
SAINT PAUL, MINNESOTA 55104

$100.00 REGISTRATION FEE

DIARRHEA

TROCINATE

BRAND THIPHENAMIL HCl

The first 400 mg. Trocinate tablet usually relieves discomfort so promptly that Diarrhea ceases to be a bother

Trocinate has no known therapeutic value other than relaxing smooth muscle by direct action when coming in contact with the spastic muscle cell. Trocinate has none of the troublesome side-effects of anticholinergic drugs. Trocinate relieves the discomfort of diarrhea by decreasing both peristalsis and muscle tone. Trocinate is metabolized by the body and eliminated in the urine as harmless degradation products. Normal intestinal function is resumed.

The action of Trocinate is prompt, making the spacing of dosage easy. Often one or two 400 mg. tablets are sufficient to control diarrhea. The recommended dosage in spasm of the G. I. and G. U. tract is 400 mg. q. 4 h. A prescription of twelve (12) 400 mg. tablets will, in most cases, allow the patient to have a few to keep in reserve.

Literature and samples available

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856

TROCINATE®

BRAND THIPHENAMIL HCl

DIARRHEA

now she can cope...



thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.

In childhood diarrheas...



- careful supervision
- electrolyte replacement
- specific anti-infective therapy

and...

LOMOTIL®

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate ..... 0.025 mg.

LOMOTIL, in conjunction with specifically indicated medical management, may be lifesaving in children with severe diarrhea.

Lomotil lowers the excessive intestinal propulsion characteristic of diarrhea. This reduction of precipitate intestinal flow allows a normal or more nearly normal reabsorption of fluid and electrolytes and counteracts the dehydration so hazardous to children.

Moreover, eight years' experience has demonstrated that Lomotil controls diarrhea with a minimum of unwanted secondary actions.

Senra del Valle and his associates[1] conducted a study of 477 children with diarrhea, most of whom were hospitalized with the disorder. Lomotil, used in 407 of the children, shortened the duration of the diarrhea.

Grinszpan, Goldstein and Divito[2] used Lomotil in 20 children with diarrhea and also reported a prompt disappearance of diarrhea. Harris and Beveridge[3] in a double-blind study of 50 children with diarrhea, however, found no clear pattern to suggest that Lomotil influenced the course of the condition.

Michener, Brown and Turnbull[4] added evidence supporting the beneficial effects of Lomotil in 80 children, concluding that Lomotil was highly useful in controlling abdominal cramping, diarrhea and hypermotility.

Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children: Total Daily Dosage

3-6 mo. . . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . . 1 tsp. 5 times daily (10 mg.)
Adults: . . . . 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful

Maintenance dosage may be as low as one-fourth the initial daily dosage.

References:

1. Senra del Valle, A.; Linfante de Rufinelli, E. B.; Brumetti, E., and Rossi, R. H.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *127*:475-484 (Oct. 4) 1965. **2.** Grinszpan, I. L.; Goldstein, A., and Divito, J.: El chlorhidrato de difenoxilato en las diarreas infantiles. Sem. Med. (Buenos Aires) *125*:758-763 (Aug. 27) 1964. **3.** Harris, M. J., and Beveridge, J.: Diphenoxylate in the Treatment of Acute Gastro-Enteritis in Children, Med. J. Australia 2:921-922 (Nov. 27) 1965. **4.** Michener, W. M.; Brown, C. H., and Turnbull, R. B., Jr.: Ulcerative Colitis in Children. II. Medical and Surgical Therapy, Amer. J. Dis. Child. *108*:236-242 (Sept.) 1964.

SEARLE

Research in the Service of Medicine



THE BETTMAN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



When you take an electrocardiogram you expect dependable, trouble-free performance, even under difficult conditions. You want to be sure your patient's tracing is diagnostically accurate; clear in detail. The Burdick EK 4 has the frequency response, the reliability and the serviceability you want and should have. If your present ECG does not provide the significant improvements that have been designed into cardiograph equipment in recent years, you may not be providing the service you want for your patients. You need the best, and this is what you get with the Burdick EK 4. It's what Burdick stands for. See your Burdick dealer for complete details.

THE BURDICK CORPORATION
MILTON, WISCONSIN 53563

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit, Michigan 48201
Telephone: TEmple 2-4444



MSMS PRESIDENT James J. Lightbody, M.D., right, discusses organizational matters with AMA President Dwight L. Wilbur, M.D., left, before the Economic Club address. Austin Smith, M.D., center, President of Parke-Davis, introduced Doctor Wilbur at the luncheon.



A WARM WELCOME to Detroit is extended to AMA President Wilbur by James C. Danforth, Jr., M.D., left, president of the Wayne County Medical Society, and Donald N. Sweeny, Jr., M.D., Detroit, one of the MSMS Delegates to the AMA.

OFFERS 8 IDEAS IN DETROIT SPEECH

AMA President Urges Cooperation To Control Health Care Costs



ALL DETROIT NEWSPAPERS, radio and TV stations were represented at a news conference for AMA President Wilbur before the luncheon.

"What Can We Do About Health Care Costs" was the topic for the speech by Dwight L. Wilbur, M.D., AMA President, before the Economic Club of Detroit, January 13.

The AMA President offered many suggestions but stressed that "the most important of all is the increased adoption of the principle of spreading the costs of medical and hospital care over a long period, as long a period as is reasonable, for each individual or group." He added, "this can be done by voluntary prepayment, by taxation or by installment paying after the charge has been incurred."

Doctor Wilbur offered the following proposals to control the cost of health care:

1. Reduce every stay in the hospital to the absolute minimum necessary for the best possible care.

2. Avoid hospitalization entirely — by using extended care facilities, nursing or convalescent homes, or through home health services.

3. Encourage insurance and prepayment carriers to expand coverage to eliminate the requirement for hospitalization before drawing benefits.

4. Carry comprehensive insurance or prepayment coverage.

5. Support the principle of income tax credits for health insurance.

6. Develop and encourage wider use of reliable automated laboratory procedures.

7. Oppose any pattern of medical care that mechan-









AMA PRESIDENT WILBUR DISCUSSES HEALTH COSTS

AT RIGHT, AMA President Wilbur exchanges comments with Brock E. Brush, M.D., left, WCMS Past President and MSMS Public Relations Committee Chairman.

izes, automates or otherwise de-humanizes the patient-physician relationship.

8. Conduct more studies to make care more efficient and economical in the hospital.

Doctor Wilbur said the medical profession can help reduce health care spending by the people "but only if those people and their governmental, industrial, business and labor organizations are willing to cooperate."

"Let us by all means," pleaded AMA President Wilbur, "work together and work hard to control the cost of health care and to help reduce the necessary expenditures for it."

Following are some excerpts from Doctor Wilbur's address:

"Rational people should have a sense of values. How often it is the person who increases his need for health care by smoking three packs of cigarettes a day at a cost of $450 a year who shouts the loudest about health care costs!

"The increase in health care costs is closely wrapped up with the entire pattern of costs in our economy. Almost everything . . . and especially everything that has become much more advanced and complex . . . has risen substantially in cost.

"The health field has been subject to many other pressures. The basic one has been a fantastic increase in demand . . . that has multiplied geometrically while the number of skilled, educated and trained people to provide the care could at best be increased only arithmetically.

"Much of today's higher demand for health care is stimulated by massive governmental programs that offer total or partial payment for services, but do little or nothing to produce additional manpower or other resources.

"Demand has been strained by growth of the population at the old and young ends of the age spectrum, which need the most care, while the middle group — from which health care personnel must come — has grown comparatively little.

"Basic to any solution is a change in public attitude . . . a modification of unrealistic expectations.

"We who are in medicine or business, along with our colleagues in government, labor, education and other elements of society, must not promise instant solutions for complex and difficult problems, instead, we must promise to work together to do everything that can be done to solve the problem in all of its aspects . . . but with the help of all the people . . . and always preserving the freedom of our system and of all who are involved, either as providers or consumers."





PHOTOS OF THE MSMS regional conferences on medical manpower at Battle Creek, Grand Rapids and Bloomfield Hills appeared in the January Photo Section. The fourth session was held at Saginaw where Robert J. Mason, M.D., MSMS President-Elect, standing, described the MSMS proposals. Sixty-five physicians and civic leaders from the thumb area and Central Michigan attended. Seated at the head table were, left to right, MSMS Councilor Edward Rodda, M.D.; Warren Huff, MSU Trustee; MSMS Vice Speaker V. V. Bass, M.D.; and Edward F. Kickham, M.D., Saginaw County Medical Society President.



DAVID M. HUME, M.D., right, a Muskegon native, received the Virginia Association of the Professions Award recently for "his unselfish contributions to the field of medicine and to his fellowman." Doctor Hume, chairman of the Department of Surgery at the Medical College of Virginia, is shown above at the 1968 MSMS Annual Session where he spoke about transplants. Left above is Alexander Walt, M.D., 1968 Annual Session program chairman, and M. Betty Bennett, M.D., Africa, another speaker.

WORK IS UNDERWAY on the new Grand Rapids Public Museum "New Life and Health Exhibit" financed by the Kent County Medical Society as a community-service project. A model of the display area is held by Charles Farber, M.D., immediate past president, and James Muldoon, M.D., public relations committee chairman. Auxiliary members plan to conduct school tours when the "Story of Reproduction" and other exhibits are completed this spring. (Grand Rapids Press photograph)





PLANS FOR THE 1970 White House Conference on Youth are well underway in Michigan with two physicians serving as co-chairmen of the health committee. The Michigan Youth Commission-directed efforts will focus on the "Minus Zero to Five Year Olds." Left to right at a planning session are Jon Wallis, Kalamazoo, Chairman of the Youth Advisory Council; Elizabeth Wheeler, Central Michigan University Health professor; Irvin Posner, M.D., Detroit, Eleanor Skufis, M.D., Adrian; and MYC Executive Sam Rabinovitz. Doctors Posner and Skufis lead the health committee plans.



THE GRAND RAPIDS FOUNDATION has made many grants to hospitals there to improve patient care. In the photo, a physician taps amniotic fluid for analysis in a new recording spectrophotometer, given by the Foundation, to determine Rh blood type of the unborn baby.



MRS. ALLAN GASPERSON, right, Mt. Clemens, received the Michigan Blue Shield Emmy trophy for 1968. Neal McCue, left, Blue Shield vice president for professional relations, and Helen Schick, education coordinator, presented the award to Mrs. Gasperson for her "outstanding leadership and many contributions to the advancement of the medical assistant profession in Michigan." She is the immediate past president of the Michigan State Medical Assistants Society.

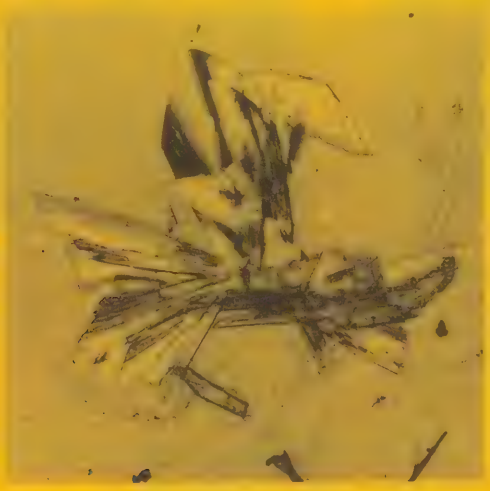


Methods of keeping office records were more familiar to second-year MSU medical student Richard Marra after he visited pediatrician D. W. Thaden, M.D., also of East Lansing. He and about 20 other MSU students were familiarized with various medical practices — their problems, volume of medical care, economics and relationship to ancillary personnel during the Christmas-holiday visitations jointly sponsored by MSMS and the MSU chapter of SAMA.



Timothy B. Jolley, second-year medical student at Michigan State University, tried his hand at office procedures while visiting Williamston general practitioner Donald R. McCorvie, M.D., during Christmas term break.

SNOWFLAKES? Yes? No? Well, you may have guessed that the photos are not snowflakes. But what are they? At left, is a photomicrograph of silicon epitaxial wafer and at right, a photomicrograph of Vitamin B-1. **(Photos by the Merck, Sharp and Dohme Laboratories)**





Selig B. Neubardt, M.D., of New Rochelle, N.Y., talked with student Nancy McGraw, left, and William B. Weil, right, chairman of the Michigan State University Department of Human Development, before giving one of the opening lectures of the university's seven-week symposium titled "Sexuality: A Search for Perspective." Doctor Neubardt, discussing "Observations of a Practicing Gynecologist," argued for contraception instruction, the right to abortion on demand and long engagement periods.



CHECKING THE MONITORING devices in the new controlled-environment room at the University of Michigan Hospital's Clinical Research Unit are A. L. Hanson, factory representative, Arthur B. French, M.D.M. CRU director, and A. C. Kerlikowske, M.D., hospital director.



FOR THE FIRST TIME in Michigan, a vertical laminar air flow system has been installed in the University of Michigan's Clinical Research Unit. The system is designed to eliminate practically all danger of infection from airborne bacteria and viruses. The unit provides a complete change of air through the perforated ceiling and floor 600 times an hour.

Smoking - Health Council To Include Doctors In All '69 Projects

The Michigan Council on Smoking and Health will help implement a four-point program for 1969 which will include doctors in each phase.

Following a recent meeting at which the Council discussed its campaign to reach youth, parents, teachers and physicians in the coming year, Benjamin Yep, Council executive, discussed the doctors' part in the activities.

In the first three phases, explained Mr. Yep, physicians are invaluable as resource persons, providing youth and teachers with information regarding the medical side of the problem and often serving as keynote speakers at PTA programs on the topic.

"Almost all studies from the American Cancer Society and the Department of Public Health point to the physician as the single most important source of information and persuasion in the program against smoking," says Mr. Yep. "If we can encourage the physician to speak out to his patients and the public," he continues, "he, more than any other person, can do more to persuade youth to not take up smoking and adults to stop."

The fourth phase of the program is aimed at educating physicians about the smoking and health problem and that is already a heartening subject to smoking and health crusaders, says Mr. Yep.

Only 25 percent of doctors in the U.S. now smoke, he says, in comparison to 50 percent of the general population. "This is the only professional group we can point to with such a dramatic reduction in numbers of smokers (down 100,000 in the last 10 years)," says Mr. Yep. "Doctors are thus especially effective as examples."

The Michigan Council on Smoking and Health, which includes MSMS as a member, is involved in several projects which were reported in the meeting.

Council members working with youth are meeting monthly with the Michigan Youth Advisory Council made up of representatives from each of the 30 major youth organizations in the state, and are planning to administer 1,000 survey forms to pre-teens throughout Michigan in spring or fall of 1969.

A PTA Planning Guide has been distributed to all 2,200 local PTA units in the state and the state PTA smoking and health project has gained nation-wide recognition.

SMOKING-HEALTH EDUCATIONAL PROGRAMS are being offered Michigan parents by the PTA with the cooperation of many groups. Representing the various groups involved are, left to right, Charles Boyd of the Michigan Youth Commission; Ed Rice of the Michigan Department of Education; Mrs. Mary Palmer of the Michigan Congress of Parents and Teachers; and Benjamin Yep, coordinator of the Council on Smoking and Health. Many physicians are helping the PTA effort as advisors and program participants.





A large new MSMS public service exhibit on quackery has been prepared for use by county medical societies, along with a 16mm, 28-minute film which can also be provided. Based on factual information from the AMA booklet, "Facts on Quacks," the exhibit, through a salescaster message, invites persons to write for a free copy of the booklet. Among the first to be interested in the large exhibit were Mrs. R. Fred Hauer, District Vice President of the Auxiliary to MSMS, which is carrying on a special quackery educational effort, and Kenneth H. Johnson, M.D., MSMS Secretary. The exhibit will make its first appearance in Jackson Feb. 18-19, and then in Detroit March 14.

INFORMATION for an article in the **AMA News** is obtained from U-M Dean William N. Hubbard, Jr., M.D., by William H. Spelbring, AMA associate editor, about the MSMS and medical school efforts to expand. Mr. Spelbring spent three days in Michigan interviewing the three deans, MSMS officials, leaders of labor, the rural community, etc. The article will appear in February.



DRUG ABUSE EDUCATIONAL EFFORTS are being encouraged by the AMA and MSMS. The materials, at right, are available in a Drug Abuse Kit from the AMA, 535 N. Dearborn, Chicago, 60610. This issue of **Michigan Medicine,** with its photographic cover, carries a special article beginning on page 137 to describe what several county medical societies are doing.





"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin plus belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation. A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT! ROBITUSSIN



THERE'S A FORMULATION FOR EVERY COUGHING NEED

All five members of the Robitussin family contain glyceryl guaiacolate. This outstanding expectorant agent increases the output of lower respiratory tract fluid (R.T.F.) Increased R.T.F. volume thins mucus, thereby improving the action of bronchial and tracheal cilia and making thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"

ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Alcohol, 3.5%

For unproductive, allergic coughs

ROBITUSSIN A-C® (exempt narcotic)
Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Pheniramine maleate ..... 7.5 mg.
Codeine phosphate ..... 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control

ROBITUSSIN-DM®
Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Dextromethorphan hydrobromide 15.0 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"

COUGH CALMERS™
Each Cough Calmer contains:
Glyceryl guaiacolate ..... 50 mg.
Dextromethorphan hydrobromide .. 7.5 mg.

Clears sinuses and nasal stuffiness as it relieves cough

ROBITUSSIN-PE®
Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Phenylephrine hydrochloride ..... 10.0 mg.
Alcohol, 1.4%

	Robitussin	Robitussin A-C	Robitussin-DM	Cough Calmers	Robitussin-PE
Expectorant	●	●	●	●	●
Demulcent	●	●	●	●	●
Cough Suppressant		●	●	●	
Antihistamine		●			
Non-Narcotic	●		●	●	●
Long-Acting (6-8 Hours)			●	●	
Nasal, Sinus Decongestant					●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

DEAN HUNT OUTLINES GOAL

Chairman of Advisory Comprehensive Planning Council Describes Concepts

The role of comprehensive health planning in Michigan is to act as a catalyst for effective planning with emphasis on effectiveness at the local level, to act as a clearing house for planning efforts throughout the state, and to involve the consumer in the planning process.

These general concepts were outlined by Chairman Andrew D. Hunt, Jr., M.D., to the first meeting of the new Michigan Advisory Council on Comprehensive Health Planning.

Chairman Hunt, who is also dean of the MSU College of Human Medicine, suggested that efforts to carry out these general goals will encounter many problems — such as medical care costs, facilities planning, services and programs, urban population, rural problems, health manpower, health hazards, etc.

DOCTOR HUNT DISCUSSED his concepts of planning as related to the new Council, and what comprehensive health planning is and is not.

Comprehensive health planning in Michigan, as developed through Public Law 89-749 which created the Council, is not a government takeover, not competitive with or contradictory to the intent of the Regional Medical Program legislation, and not a program to channel federal funds exclusively to state governmental health agencies, he said.

"The interrelationship between comprehensive health planning and regional medical programs is obvious," said Doctor Hunt. "They are essentially complementary to each other and appropriate overlap between membership on this Council and the Regional Medical Programs Advisory Group has been arranged. Thus, constant communication between these two groups is assured."

The emphasis on partnership with voluntary planning agencies and the professions and the insistence on consumer involvement in decision making, continued the chairman, indicates that financial strengthening of government health agencies should be recommended only as such is clearly indicated as necessary to augment the effectiveness of the planning process in the interest of the people.

The Comprehensive Health Planning legislation recognizes that the end-point of successful health care is the satisfaction and health of the consumer. As this Council widens its efforts, then, and develops sub-groups to investigate improved care for our urban and rural disadvantaged citizens, heavy involvement of these citizens themselves in the planning efforts will be essential." Perhaps the most important move of the new Michigan Advisory Council on Comprehensive Health Planning will be to involve the consumer in its programs, he said.

Chairman Hunt noted that medical costs have risen faster in Detroit than in any other metropolitan area over the past 15 years, with doctor bills and hospital costs 95 percent higher there by December 1967 than they were in December, 1952.

"The answer to this problem is unclear at best," said Doctor Hunt, "but the inevitable result of our private medical care pricing itself out of the market is its downfall. A primary purpose of this Council must be to study ways and means of keeping health care costs reasonable."

The Council must study ways to aid and abet hospital planning to eliminate duplications, coordinate services and keep costs within reason, he continued.

"But while the hospital issue is vital, the considerations of this council must extend far beyond, and must include the availability of services in communities, their quality, their accessibility, with the end-point of success being improved health," he said.

To help alleviate the manpower shortage, the development of comprehensive health planning should identify areas of need, consumer perceptions of such needs and provide data to aid universities, colleges and private institutions to be more effective, Doctor Hunt said.

Consideration of air and water pollution are clearly essential in any comprehensive health planning effort, he said, but housing conditions,

(Continued on Page 166)

5 ON COMMISSION; OFFICE IN LANSING

The Comprehensive State Health Planning Commission, appointed by the Governor, includes R. Gerald Rice, M.D., Chairman; Charles Orlebeke, Vice-Chairman; William H. Anderson, M.D.; R. Bernard Houston, and Glenn S. Allen, Jr. The Executive Director is Mrs. Betty Tableman, and the executive office is in the Lewis Cass Building, Lansing 48913.

Two good reasons to specify LEDERCILLIN® VK

Potassium Phenoxymethyl Penicillin

1. It's a Lederle product.
2. Low price.

Tablets:
250 mg—100's and 1000's
For Oral Solution:
125 mg/5 cc—80 cc and 150 cc
250 mg/5 cc—80 cc and 150 cc

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

9-7-1041/461-9

NEW



poverty, racial discrimination and the adequacy of the public schools are of enormous significance, also, and modern health planning therefore becomes an integral part of the very basis and matrix of society.

"Comprehensive health planning, then," said Doctor Hunt, "could develop as an agent to undercut the poverty cycle."

Planning, defined the doctor, is a continuing and dynamic process which to be effective must occur at the local community level and be in continuous operation. It cannot be supervised or controlled from any governmental or centralized agency.

Thus the role of the Council becomes one of a catalyst, and it should explore, said Doctor Hunt, the valid areas of centralized statewide planning. They might include a statewide plan for provision of professional services in the sparsely-settled areas, improvements of strategically located hospitals and even exploration of the possibility of utilizing systems analysis techniques at a central level to define the dimensions of such a program.

"We also can look specifically at more or less categorical dimensions of the health problem," he continued, "for example, nutrition, child care, nursing home care and vision," he continued.

"The intent of this law is far-reaching, idealistic and therefore unspecific and frustrating to those of us who are accustomed to making decisions on the basis of limited objectives, crisp tangible issues and easily comprehended and well-presented factual data," observed Doctor Hunt.

"These very complexities, uncertainties and idealistic concepts, however, are what propelled me into accepting the governor's request that I chair this Advisory Council and which should make service on this Council an exciting opportunity for all of us, and a vitally important service to the welfare of the people of Michigan."

COMMUNITY TUMOR BOARD ORGANIZING IN LANSING

A new Community Tumor Board is being formed in Lansing and will begin work in March.

"It has been the feeling of a number of physicians in this community for some time that there was a need for such a board and we felt we should start it," said R. C. Melick, M.D., chairman of the Ingham County Medical Society's Hospital Relations Board, under whose guidance the new body is being developed.

Purpose of the Tumor Board is (1) to act in an advisory capacity to the physician in determining the type of therapy best for his patient, (2) to provide a mechanism for the continuing education of the physician in regard to current tumor therapy, and (3) to consider forming a Tumor Registry and Research in Tumor chemotherapy.

Instrumental in organizing the new group were William Meade, M.D., Lansing, and Joseph R. Cipparone, M.D., Lansing, who had long talked about the need of such a committee. Doctor Cipparone now heads the Tumor Board.

Members of the board will include a pathologist from each of Lansing's four hospitals, a radio therapist from each hospital, and two (the second an alternate) oncologists, surgeons, internists, gynecologists, ophthalmologists, urologists, otolaryngologists, pediatricians, neurosurgeons, chest surgeons, orthopedic surgeons, dermatologists, plastic surgeons and a full time secretary.

Any physician is welcome to attend the meetings, which will be held the last Friday of the month beginning in March, from 11:45 a.m. to 1 p.m. at Lansing's St. Lawrence Hospital.

Several cases will be presented at each meeting. A protocol of the cases to be presented will be made available to the members of the tumor board and anyone else interested, one week before the meeting.

The cases will be presented by the attending physicians and the patient will be present when possible for examination or questioning. Films and pathology slides of each case will also be present for study.

The secretary will record the proceedings of the meeting and will inform the attending physician in writing of the recommendation of the board, which will also be made a part of the tumor board records of each patient for future follow-up.

HEW GRANT TO HELP FINANCE DETROIT REHAB INSTITUTE

Plans to construct a three-story, $3½ million addition to the Rehabilitation Institute in the Detroit Medical Center were announced recently by Joseph N. Schaeffer, M.D., hospital's director. A total of $100,000 in Hill-Burton government funds has been granted to the Institute by HEW to help finance the new addition.

Construction, scheduled to begin in the spring, will nearly double the bed capacity of the existing six-story hospital.

Included in the expansion will be an additional 89 beds, increasing capacity to 185, offices and adjunct facilities. Present areas of the hospital also will be renovated.

MSMS Council Chairman Urges AMA to Take Leadership on Hong Kong Vaccine Distribution

The shortage of Hong Kong flu vaccine in Michigan caused considerable consternation and an appeal from Ross V. Taylor, M.D., Chairman of The MSMS Council, was made to the AMA that it take the leadership to work with representatives of public health and the Pharmaceutical Manufacturers Association to develop guidelines for distribution in the future.

The developments during late December and early January are traced by printing a series of letters which followed newspaper accounts that the Bell Telephone Company had obtained vaccine for their workers, at a time when many physicians and hospitals had been unable to secure adequate vaccine.

* * *

A letter was sent by Doctor Taylor to the president of Parke-Davis on December 20:

Austin Smith, M.D., President,
Parke-Davis and Company,
Joseph Campau at River,
Detroit, Michigan

Dear Doctor Smith:

As chairman of The Council of the Michigan State Medical Society, I question the decision of the Parke, Davis and Company to sell 7,000 doses of the Hong-Kong flu vaccine to one single Detroit firm — before meeting the needs of Michigan physicians to protect the aged and those suffering with chronic diseases.

Many physicians are unable to obtain enough of the vaccine for their elderly patients and for those suffering with chronic diseases, especially the chronic heart and lung cases — which rightfully should be first priority. I understand that many hospitals have not been able to obtain the vaccine which they feel is needed.

Your firm, I feel, has made an error in diverting the 7,000 doses to the Bell Telephone Company to help protect their workers rather than make adequate vaccine available first to physicians to give to their top priority patients.

Sincerely,
Ross V. Taylor, M.D.

* * *

Doctor Taylor received letters supporting his stand from several physicians, including one from Doctor Beckwith of Stockbridge, dated December 26.

Dear Doctor Taylor,

The December 25th issue of the Jackson *Citizen-Patriot* carried three articles on the use of over one-third of the first issue of the so-called "Hong Kong Flu" vaccine by Michigan Bell Telephone Company and sold to them by Parke, Davis & Co. These articles included a condemnation of the action by Ross V. Taylor, M.D., a statement by John L. Isbister, M.D., chief of the Bureau of Community Health, commending Michigan Bell in that it "operated with the private enterprise system," that Parke, Davis had a "perfect right" to sell the vaccine to Michigan Bell, and that the telephone company showed "foresight" in putting in such a large order. A third article was a charge that Parke, Davis & Co. had violated U.S. Public Health Service recommendations, a charge made by State Senator Roger E. Craig of Dearborn. In answer to this charge, Doctor Isbister said the Health Department will check to see if any irregularities have occurred.

In the light of the good doctor's quoted comments above, what confidence can anyone have of his findings?

Although it is improbable that administration of one injection of this vaccine will establish any great immunity during the present epidemic, the attitude of "the public be damned" assumed by our big corporations and by the pharmaceutical industry demands consideration of both the professional man and the public at large.

Each time there is an epidemic in prospect, the private patient in poor health, and the elderly in

need of any protection that can be afforded must wait until after the big corporations have gobbled up the lion's share of the available material for free distribution to its healthy employees. If public opinion is of no effect in this corporation-drug company symbiosis, perhaps the power of the buck may be a little more effective. I have personally begun my own boycott on Parke-Davis products and I suggest that some such action by others in the profession might show Parke-Davis that it cannot thumb its nose at the public need.

— Sidney A. Beckwith, M.D.
Stockbridge

* * *

A letter was sent by Doctor Taylor to the AMA on December 27:

Ernest B. Howard, M.D.,
Acting Executive Vice President,
American Medical Association,
535 North Dearborn Street,
Chicago, Illinois 60610

Dear Doctor Howard:

Here in Michigan, and also in other states across the country, there have been problems in the distribution of flu vaccine. Specifically, some corporations have been getting some of the vaccine and private physicians are getting very little for their chronically ill patients.

I have talked with an officer of the Parke, Davis Company and they thought that their distribution plan followed the national guidelines set by public health officials. Nowhere, however, does the public health guideline provide for distribution for the benefit of private patients, except for the general statement of priority to the aged and chronically ill.

The Parke Davis officer and the Michigan State Medical Society believe that more force could be given to guidelines if they were to be developed jointly on a national level by representatives of public health, the American Medical Association, and the Pharmaceutical Manufacturers Association. Most of the aged and chronically ill are still under the care of practicing physicians.

This is a service in which the American Medical Association should take the leadership and it would be hoped that it could be implemented at an early date so that future distribution problems can be avoided, if not in this epidemic then at least in all future epidemics.

Sincerely,

Ross V. Taylor, M.D.
Chairman of The Council

A letter was sent December 30 from William Jend, Jr., M.D., medical director of Michigan Bell Telephone Company, to Doctor Taylor:

Dear Doctor Taylor:

The use of inaccurate information and gratuitous comments about Michigan Bell Telephone Company in statements attributed to you about the influenza vaccine situation in *The Detroit Free Press* for December 25th is difficult to understand. There had already been sufficient misunderstanding among the medical profession and the general public about our role in this matter.

As official spokesman for the Michigan State Medical Society you have a responsibility, especially to the over-200 members of the Society who render professional service for this Company, to set the record straight:

1. Because of disastrous experience in trying to maintain telephone service during influenza epidemics in the past and in accordance with recommendations of the U.S. Public Health Service for essential industry, we have carried on influenza inoculation programs among our employees for a number of years.

2. When we learned in late summer that the Hong Kong strain could not be included in the regular 1968 influenza vaccine, we let our suppliers know we wanted to order the Hong Kong vaccine.

3. We did not ask for any preferential handling of our order and we have always cooperated fully in any allocation or priority system.

4. We were actually able to purchase considerably less than half of the 12,000 doses we wanted to order — far less than the 7,000 dose figure you used — and we inoculated only a portion of our 28,000 employees.

5. There is a great deal of difference in operating this business during a strike, when absence is predictable and only essential service is provided, and during a sickness epidemic, when absence among employees from day to day is not known in advance.

It remains to be seen whether the timing and manner of entry of the Society into this problem has been helpful to our patients and contributed to a constructive solution. The possibility of a scarcity of vaccine might well have been anticipated several months ago by Society officials and discussions held at that time with public health officials and vaccine manufacturers. We at Michigan Bell would have strongly supported such an approach.

I respectfully request that this letter be brought

(Continued on Page 170)

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road **Conducted by Sisters of Mercy** **Ann Arbor, Michigan**

Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

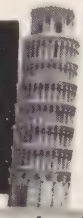
Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

Lyle M. Allis, M.D.
Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.*
Sydney Joseph, M.D.
Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Richard D. Watkins, M.D.
Stephen C. Mason, M.D.
Philip M. Margolis, M.D.
Hubert Miller, M.D.

* 1904 - 1967

in the treatment of **IMPOTENCE**



Android®
(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY
ANDROID — GOOD TO EXCELLENT 75%
PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

***"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android
Each yellow tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 10 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY
Each red tablet contains:
Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY
Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . . 64 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (¼ gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
Glutamic Acid . . . . . 100 mg.
Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 . . . . . 2.5 mcg.
Riboflavin . . . . . 5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

REFER TO PDR

also available with ESTROGEN

Android-E
Each Tablet Contains:
Methyl Testosterone . . . . . 2.5 mg.
Ethinyl Estradiol . . . . . 0.02 mg
Thyroid Ext. (1/6 gr.) . . . . . 10 mg.
Thiamine Hydrochloride . . . . 10 mg
Glutamic Acid . . . . . 50 mg

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS:** See Android, Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Write for literature and samples:
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

to the attention of the entire membership of the Society as soon as possible.

— William Jend, Jr., M.D.
Medical Director

* * *

Doctor Taylor replied to Doctor Jend's letter on January 31:

Dear Doctor Jend:

I am sorry that your feelings were ruffled by newspaper accounts concerning my letter to Parke-Davis objecting to their distribution of the Hong Kong flu vaccine. I did not object to Michigan Bell ordering the vaccine and recognized that the problem was in the distribution of the vaccine by Parke, Davis and Company.

The order of priority recommended by the Public Health Department nationally was as follows:

1) Those most likely to suffer the highest mortality and morbidity, namely the aged and seriously or chronically ill, especially those with heart and/or lung diseases.
2) Essential health personnel such as nurses and other hospital or nursing home employees, physicians, public health nurses, etc.
3) Essential public employees such as policemen, firemen, etc.
4) Essential utility workers supplying heat (gas and fuel oil), electricity and telephone services.

While these national guidelines were not specifically numbered as I have listed them, they were essentially in that order. At the time I wrote to Parke-Davis, many hospitals had received no vaccine and most physicians had no vaccine. Obviously most of the aged and/or seriously or chronically ill patients are in hospitals, nursing homes, public institutions, or under the care of private physicians. Repeatedly in years past in epidemic situations, physicians in many communities have seen corporations and industrial plants receive vaccine for mass inoculations while their own orders were unfilled.

The problem is a national one and for that reason I have also written the AMA. All of the six pharmaceutical firms manufacturing vaccine distribute nationally and others than Parke-Davis have also in the past supplied corporations and industrial firms first.

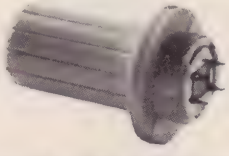
I apologize for the error in the amount of vaccine received by Michigan Bell Telephone. I don't believe it was a "gratuitous comment" to point out the obvious fact that Michigan Bell has been able to carry on effectively during a strike. This fact is a well-documented piece of public information.

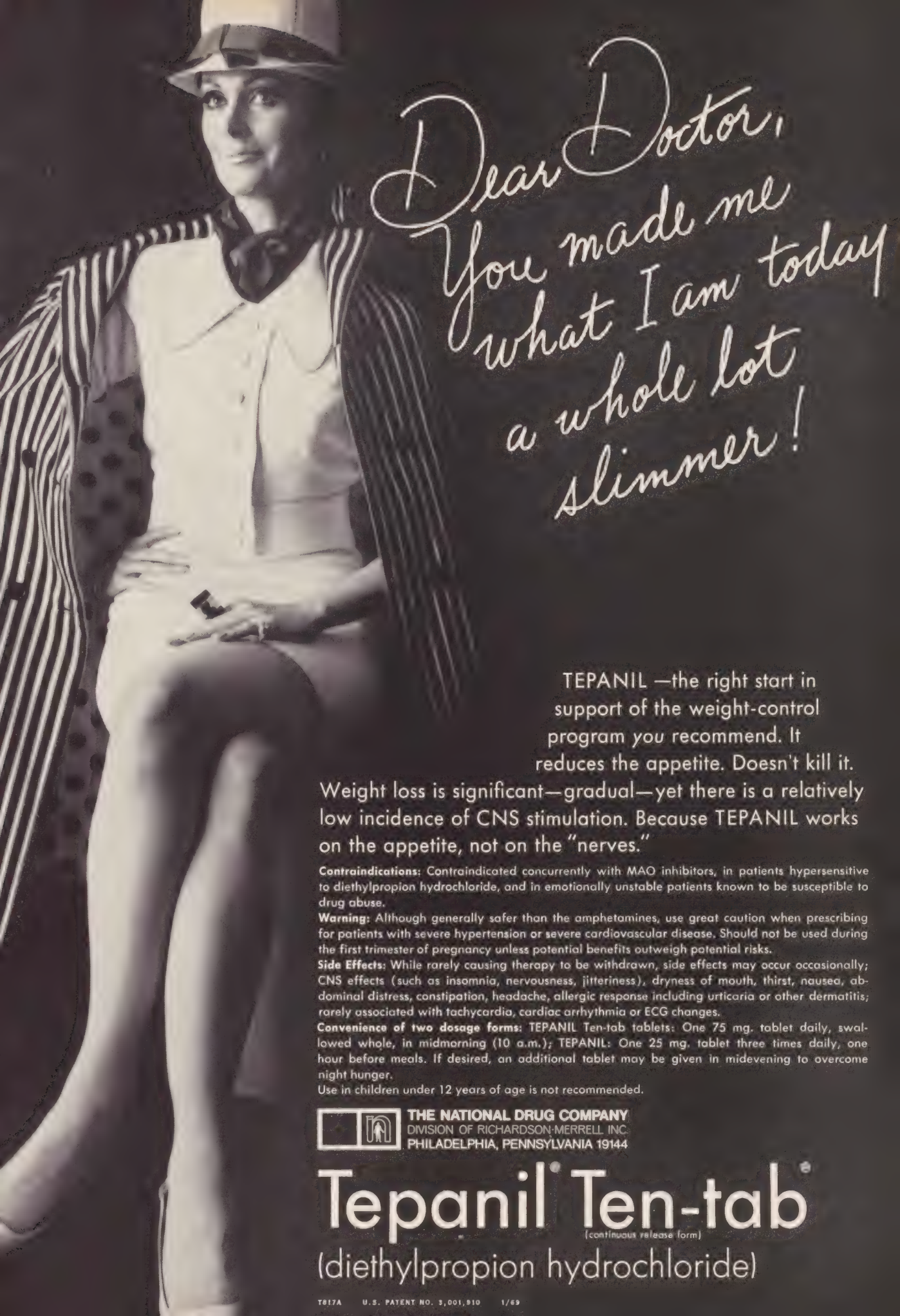
I don't think it should be necessary to point out that as physicians we are dedicated to the preservation and protection of life and that for this reason those individuals most likely to suffer mortality and morbidity should receive the first available vaccine.

Yours truly,

Ross V. Taylor, M.D.
Chairman of The Council

ROSELAWN MANOR
A Convalescent - Retirement Residence for Senior Citizens
Offering complete convalescent care with a complete staff of nurses and attendant personnel for every need in 220 units.
707 ARMSTRONG RD., LANSING, MICH. 48910
Phone 393-5680

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or
HISTO?
(Histoplasmosis—"The Masquerader")

A new aid in differential diagnosis
HISTOPLASMIN, TINE TEST (Rosenthal)
The LEDERTINE™ Applicator with the Blue Handle
Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).
Lederle
Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8



TEPANIL —the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Contraindicated concurrently with MAO inhibitors, in patients hypersensitive to diethylpropion hydrochloride, and in emotionally unstable patients known to be susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use great caution when prescribing for patients with severe hypertension or severe cardiovascular disease. Should not be used during the first trimester of pregnancy unless potential benefits outweigh potential risks.

Side Effects: While rarely causing therapy to be withdrawn, side effects may occur occasionally; CNS effects (such as insomnia, nervousness, jitteriness), dryness of mouth, thirst, nausea, abdominal distress, constipation, headache, allergic response including urticaria or other dermatitis; rarely associated with tachycardia, cardiac arrhythmia or ECG changes.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger.

Use in children under 12 years of age is not recommended.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Tepanil® Ten-tab®
(continuous release form)

(diethylpropion hydrochloride)

T817A U.S. PATENT NO. 3,001,910 1/69

Explaining How Michigan Laws Are Made . . .

BY M. A. RILEY
MSMS LEGISLATIVE COUNSEL

The creation of a new law by the Michigan State Legislature is a somewhat complex process, and the steps by which it is accomplished should be familiar to all those interested in affecting the course of a bill.

A new law, of course, starts with an idea which may be developed by an individual legislator, or one of his constituents, an organized group, or possibly an instrumentality of the government itself. The idea is generally outlined to a specially staffed arm of the Legislature called the Legislative Service Bureau by the legislator who plans to introduce the bill.

The Bureau incorporates a number of attorneys experienced in drafting bills, plus research people and clerical staff. They check to see whether a new law is necessary or whether existing laws cover the situation; they research laws of other states; they discuss the idea with appropriate state agencies if necessary; they draft a proposed bill in the proper form and style, and present it to the legislator who requested it.

THE LEGISLATOR then may introduce the bill by himself or ask one or more of his colleagues to co-introduce it with him. His next step, if he is a Senator, is to hand the bill to the Secretary of the Senate or, if he is a State Representative, to the Clerk of the House.

At this point a proposed bill enters a process in each house which is duplicated in the other house, which is typical of a bicameral legislature.

Assuming that the bill has been presented by a Representative, it is read by title, twice, to the entire House of Representatives and then referred for study to a committee of the House. Most health matters, for example, will be referred to the House Public Health Committee or Mental Health Committee, or possibly the House State Affairs Committee (if they deal with licensure laws). It is then before the committee that most of the preliminary arguments pro and con are made, for the committee must decide whether or not the full House of Representatives will get the bill back for a vote.

AFTER A COMMITTEE has taken testimony and discussed a proposed bill it may vote (and the vote is a matter of public record) to release the bill to the floor for debate and vote. If it does so, the bill is placed on what is called a "General Orders Calendar" and, when its turn comes, it may be debated by the entire House. Amendments may be offered, and generally are. These amendments may be amendments to those already made in the original by the committee which first considered the proposal.

A bill which survives "General Orders" (that is, is not voted back to the committee from which it came, an action which generally "kills" the bill) is then placed on the "Third Reading Calendar," so called because when introduced, as stated earlier, the title of the bill had been read twice. Here it is subject to final but more limited debate (and again amendment) and a vote. The vote is "on the record." If the bill passes, it goes to the other half of the Legislature — in this case the Senate — *and goes through the same process all over again.* It is again read twice, referred, studied, put on General Orders, put on Third Reading, and voted.

Finally, after surviving the process as duplicated in both houses, the bill if passed is sent to the Governor who has a specific amount of time to consider it and the option of veto. If he vetoes the bill the Legislature has an opportunity to override him, but this action requires two-thirds of the members of both the House and Senate — a difficult number to muster. And if the Governor signs the bill, it ceases to be a bill and is then known as an "Enrolled Act" and finally a "Public Act" of the State of Michigan.

Rarely does any legislative proposal become law in the form in which it was originally introduced. Frequently, a new law is substantially different than the initial idea which prompted it. It is for this reason that MSMS may observe a particular legislative proposal during a period of several months and find it initially worthy of support, then amended so as to be objectionable, then amended again and improved, etc.

Each day the Legislature is in session all of its proceedings are published in booklets called the "Journal" of the House and Senate. These Journals are distributed to each Legislator daily and also carefully reviewed each day by the MSMS Legal Affairs Committee staff. Once a week there is published a "Status" of all legislation showing very briefly each action taken on each bill, and this is also reviewed by MSMS

THIS BRIEF REVIEW of the legislative process points up the relative importance to the system of the various legislative committees; since nearly two thousand bills are considered yearly, individual legislators must and do rely heavily upon the recommendations of their several committees. When a particular bill is assigned to the House State Affairs Committee, House members expect that committee to advise them as to its appropriateness. And members of the State Affairs Committee, in turn, do not have time to study highway or conservation proposals but will expect other legislators

on those committees to give them recommendations.

MSMS WILL, THEREFORE, find the bulk of health-related legislation assigned to a relatively few committees of the Senate and House, and the members of these committees will have a particularly large influence on the fate of bills most vital to medicine. At the same time, every single legislator has the responsibility of voting on every issue placed before him, and it is more often the case than not that bills either pass or fail by a narrow margin.

In perspective, then, a Senate-introduced bill which is awaiting "Third Reading" in the House of Representatives is but one step away from final passage or rejection; a House-introduced bill placed on the House "General Orders Calendar" has barely started on the legislative road. At each step along the way those interested in good legislation have their opportunities to make their positions known — before committees in both Houses, and through the debate periods in both Houses, and finally by making the Governor aware of their support or opposition.

The legislative system contains many checks and balances. It only works well, and to the best benefit of the public, when interested citizens keep themselves informed and take the trouble, both through their organizations and as individuals, to let their lawmakers know how they feel.

COMMITTEE CALENDAR

Every month many MSMS committees meet to develop new projects and to move along activities approved by The Council or suggested by the House of Delegates. Following is a calendar of January meetings for The MSMS Council, MSMS Committees and other official groups:

Wednesday, January 8
Committee on Eye Care
MSMS Headquarters
Chairman: Robert T. Blackhurst, M.D., Midland

Thursday, January 9
Committee on Legal Affairs
MSMS Headquarters
Chairman: Otto K. Engelke, M.D., Ann Arbor

Wednesday, January 15
Committee on Highway Injury
MSMS Headquarters
Chairman: Paul W. Gikas, M.D., Ann Arbor

Committee on Professional Insurance Plans
Canopy Restaurant, Brighton
Chairman: Robert M. Stow, M.D., Lansing

Committee on Single Medical Practice Act
MSMS Headquarters
Chairman: Fredk. S. Gillett, M.D., Grand Rapids

Thursday, January 16
Committee on Maternal Health
MSMS Headquarters
Chairman: James E. Harryman, M.D., Muskegon

Friday, January 17
Committee on Mental Health
Sheraton-Cadillac Hotel, Detroit
Chairman: Benjamin Jeffries, M.D., Detroit

Thursday, January 23
Committee on Postgraduate Medical Education
MSU Union Building
Chairman: Harry A. Towsley, M.D., Ann Arbor

Wednesday, January 29
Judicial Commission
MSMS Headquarters
Chairman: Donald N. Sweeny, Jr., M.D., Detroit

The Council, MSMS
MSMS Headquarters
Chairman: Ross V. Taylor, M.D., Jackson

Thursday, January 30
Committee on Rehabilitation
MSMS Headquarters
Chairman: L. L. Davis, M.D., Mt. Pleasant

FIFTH REGIONAL MEDICAL LIBRARY SERVES MICHIGAN

The nation's fifth Regional Medical Library serving the health professions in the states of Michigan, Ohio, and Kentucky, has been established by Wayne State University and the University of Detroit.

A $100,000 grant, made under the Medical Library Assistance Act of 1965, for the East Central Regional Medical Library was announced in Washington, D.C., by the National Institutes of Health. The central offices will be at the WSU School of Medicine Medical Library. WSU Medical School Librarian Vern M. Pings explains that the Regional Library is designed to improve the flow of biomedical information through local medical libraries to medical practitioners, researchers, and educators throughout Michigan, Ohio and Kentucky.

In addition to the University of Detroit and Wayne State University, the participating institutions are: Michigan State University, University of Michigan Cleveland Health Sciences Library, Ohio State University, Medical College of Ohio at Toledo, University of Cincinnati, University of Kentucky and University of Louisville.

Other regional medical libraries are headquartered in Boston, Philadelphia, Seattle and Chicago. Seven other regional centers are planned.



Hot under the collar...

high under the cuff.



Sometimes
he forgets he has hypertension, gets hot under the collar...high under the cuff.

For such patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6392

MVF Benefit Structure Explained

BY LOUIS F. HAYES, M.D.
VICE-PRESIDENT, MEDICAL AFFAIRS
MICHIGAN BLUE SHIELD

The previous article on Blue Shield's Variable Fee Program dealt exclusively with the payment mechanism. In this issue we outline the benefits available to the subscriber under this new contract. Also we will list the covered services, discuss the general concept of the program and compare benefits of the old and new contracts.

The covered services are:

I. Surgery*
II. Anesthesia*
III. Technical Surgical Assistance*
IV. Obstetrics*
V. Medical Care*
VI. Consultations*
VII. Emergency First Aid*
VIII. Therapeutic Radiology*
IX. Diagnostic Radiology
X. Diagnostic Laboratory

The services followed by an asterisk indicate those that have been expanded from the M-75 contract. In general, the benefit expansions fall into one of the following three categories:

1. Removal of M-75 exclusions
2. Extension of M-75 limitations
3. Addition of new benefits

One important general concept embodies the entire philosophy of the MVF Program. To the extent practicable, all coverage is based on valid medical need of services according to accepted standards of medical practice. Hence there are two guiding principles – medical validity (of the service) and medical need (of the patient). With this in mind, let us review the list of covered services.

I. Surgery

There are three general rules to consider:

1. The usual, necessary and related pre-operative and post-operative care is included in the surgical payment.

2. All medically acceptable and indicated diagnostic and therapeutic surgical procedures are covered.

3. No additional payment is made for anesthesia when given by the operating surgeon.

Following are the additions in surgical benefits under MVF:

	M-75	MVF
1. Sterilization	Not covered.	Covered - inpatient only, when medically necessary.
2. Dental Surgery	Not covered.	Covered - inpatient only, with concurrent hazardous medical conditions: a) multiple extractions b) removal of unerupted teeth.
3. Plastic Surgery for congenital anomalies not affecting function.	Covered-if: a) continuous coverage since birth. b) operated before age 12.	Exclusions removed: a) continuous coverage not required. b) surgery may be delayed beyond age 12 if medically necessary.
4. Plastic Surgery for traumatic or surgical scars.	Covered-if: a) continuous coverage from date of origin.	Exclusions removed: a) continuous coverage not required.

II. Anesthesia

The general rule covering the benefit is as follows: "Anesthesia is a benefit when administered by other than the operating physician and rendered in direct relationship to other covered services."

	M-75	MVF
1. Anesthesia monitoring service.	Not covered until July 1968.	Covered if medically indicated and requested by the operating surgeon.
2. Anesthesia for non-surgical procedures.	Not covered.	Covered if medically indicated and given by other than the examining physician. (e.g. pelvic examination)

III. Technical Surgical Assistance

This benefit was formerly limited to Michigan hospitals without intern and/or resident training programs or house officers.

This exclusion has been removed. The benefit is available in *any* hospital if the suregon certifies (upon request of Blue Shield) that intern, resident or house officer services were not available.

IV. Obstetrics

	M-75	MVF
1. Delivery	After 270-day waiting period.	No waiting period.*
2. Pre-and Post-Natal care	Not covered.	Covered.*
3. Laboratory	Not covered.	Covered - $10 maximum*

*Under MVF-2

V. Medical Care

Medical services are covered in *accredited* general hospitals, mental hospitals and rehabilitation facilities. Following are the areas of increased coverage:

	M-75	MVF
1. Inpatient medical	a) limited, 120-365 days. b) 90 day renewal period for subsequent eligibility.	a) No limit (except by medical necessity). b) No renewal period.
2. Inpatient psychiatric	a) limited - 30 days. b) 180-day renewal period.	a) Extended to 45 days. b) 90-day renewal period.
Added services:		c) Group Therapy d) Electroshock Therapy e) Family counselling f) Phychological testing.
3. Tuberculosis care (Pulmonary)	a) limited - 30 days. b) 180-day renewal period.	a) Extended to 45 days. b) 90-Day renewal period.
(Non-pulmonary)	c) as in a) and b).	c) unlimited coverage.
4. Newborn care (routine) (initial inpatient examination of newborn)	Not covered.	Covered-if rendered by other than obstetrician or anesthesiologist.
5. Diagnostic admissions	Not covered if less than 4 days.	Covered-if medically necessary.

VI. Consultations (Inpatient)

	Limited to one per admission per type of service.	No limitations — dependent on medical necessity.

VII. Emergency First Aid

	a) limited - $15 per case. b) within 24 hours of trauma.	a) up to $15 per physician for initial service. b) No time limitation.

VIII. Therapeutic Radiology

Under the M-75 contract, this benefit was limited to malignant lesions and a few specific benign conditions; there was a maximum allowance on series or courses.

All lesions which medically require this type of treatment are covered under MVF and there is no limitation on series or courses.

IX. Diagnostic Radiology

There has been no change in this benefit. All medically acceptable and necessary diagnostic X-rays are benefits. Routine examinations and screening procedures are not covered.

X. Diagnostic Laboratory

There has been no change in this benefit. All medically acceptable and necessary laboratory procedures are benefits. Routine examinations and screening procedures are not covered.

In the past there has been confusion regarding "Member's Liability." Under M-75, the following services were classified as Class II Benefits:

a) Diagnostic Radiology
b) Therapeutic Radiology
c) Diagnostic Laboratory
d) Consultations
e) Technical Surgical Assistance

Under the terms of the M-75 contract, the subscriber was liable to pay $5.00 or 10% of the fee (whichever was greater) for each service. In many instances physicians neglected to, or chose not to bill and collect for this deductible amount. This resulted in both subscriber and physician dissatisfaction.

Accordingly, under MVF, the "Member's Liability" is *removed* from the following services: (a) Consultations, and (b) Technical Surgical Assistance; but still present on the other services.

There are many contracts in the MVF Program. The greatest coverage is provided by MVF-2, which is the most popular contract. In addition to benefits indicated above, MVF-2 also includes medical care in convalescent facilities and outpatient and office psychiatric benefits. MVF-1 and MVF-NG are identical contracts, the former being sold to groups, the latter to non-group subscribers. Neither contract covers pre- and post-natal care and obstetrical laboratory charges. MVF-NG has obstetrics only on a family contract and pre-existing conditions are subject to a 180-day waiting period. The MVF-3 contract has the same coverage as MVF-1 but is a 20% co-pay contract.

Many riders are available for MVF contracts. In general, they provide for waiver of obstetrical limitations, exclusion of "Member's Liability" and continuing coverage for dependent children as well as the addition of sponsored dependents.

This presentation is intended as a quick overview of the MVF benefit structure; the actual contracts and riders should be referred to for official language. More detail is provided in Section III of the Physicians Manual. All changes to the contract are indicated in the monthly Blue Shield "Record" which should be filed in the Physicians Manual as a matter of official record.

G. C. Burr, M.D., Detroit

George C. Burr, M.D., Grace Hospital, Detroit, urologist and associate professor of urology at Wayne State University, died Dec. 10 at the age of 78.

Doctor Burr was graduated in 1912 from Wayne State University Medical School and held the American Board Certification for urology. He was on the hospital staff 46 years and WSU associate professor 19 years before retiring in 1962.

He was a member of the American College of Surgeons and held honors from the American Urological Association. He was a past officer of the Wayne County Medical Society.

R. E. DeLong, M.D., Kalamazoo

Robert E. DeLong, M.D., Kalamazoo orthopedic surgeon, died Dec. 7 at the age of 47.

A graduate of the University of Michigan Medical School, Doctor DeLong served 17 years as an orthopedic surgeon in Kalamazoo. He was a member of the Kalamazoo Academy of Medicine and the American College of Orthopedic Surgeons.

A. R. Dickson, M.D., Battle Creek

Albert R. Dickson, M.D., Battle Creek, former president of the Calhoun County Medical Society, died Dec. 5 at the age of 80.

Doctor Dickson came from Los Angeles to Battle Creek in 1932 as chief surgeon on the staff at Battle Creek Sanitarium. In 1934 he began a private practice continued until his retirement in 1960.

He served as a Navy lieutenant during World War I and was a Fellow of the American College of Physicians. He was also active in the Masons.

Edward M. Dundas, M.D., Dearborn

Edward M. Dundas, M.D., Dearborn area physician for 34 years, died Nov. 26 at the age of 67.

Doctor Dundas was graduated from the University of Western Ontario Medical School and served his internship at Harper Hospital in Detroit. He then began his Dearborn practice.

He served on the staff of Oakwood Hospital and the Dearborn Veterans Hospital.

IN MEMORIAM

Carl F. List, M.D., Grand Rapids

Carl F. List, M.D., of Grand Rapids, died Dec. 12 at the age of 66.

Doctor List was the first neurosurgeon to serve in the Western Michigan area and had gained recognition as a pioneer in the field of neurosurgery.

He received his medical degree from the University of Berlin, Germany, and his M.S. degree in surgery from the University of Michigan. He was certified with both the American Board of Neurological Surgery and the American Board of Neurology.

He was a member of the American Neurological Association, the Harvey Cushing Society, the Academy of Neurology, the Michigan Neurological Society, the American College of Surgery, the Association for Research in Neurological and Mental Disease and the Congress of Neurosurgeons.

M. J. Medvezky, M.D., Bay City

Michael Joseph Medvezky, M.D., retired Bay City doctor, died Dec. 6 at the age of 61.

Doctor Medvezky retired in June after being a member of the staffs of Mercy and General Hospitals in Bay City. He was a general practitioner and studied at both Loyola University and Marquette University Medical Schools. He also attended Michigan State Normal College.

He was a World War II veteran.

P. V. O'Rourke, M.D., Detroit

Paul V. O'Rourke, M.D., Detroit surgeon and teacher, died Dec. 23 at the age of 67.

One of the founding members of the American Association for Thoracic Surgery, Doctor O'Rourke was clinical associate professor in surgery at Wayne State University School of Medicine since 1943.

Since 1964 he had been director of the outpatient clinic at Herman Keifer branch of Detroit General Hospital. He was also on the staff at Harper, Mt. Carmel Receiving, Detroit Receiving, Detroit Memorial, St. John's and the U.S. Public Health Hospitals in Detroit and the Veteran's Administration Hospital in Dearborn.

Dr. O'Rourke was vice president of the Michigan Society of Thoracic Surgeons and a member of the American College of Surgeons, the American Association for Surgery of Trauma, the Detroit Surgical Association and the Detroit Surgical Society.

He was graduated from Creighton University Medical School, Omaha, Neb.

F. A. Roberts, M.D., Flint

Floyd A. Roberts, M.D., Flint doctor for 55 years, died recently at the age of 86.

Doctor Roberts, who retired in 1962, specialized in otolaryngology. He began his practice in Flint in 1907 shortly after graduation from Rush Medical College in Chicago. He received his bachelor's degree from Fredonia, Pa., Institute and also studied at Westminster College, New Wilmington, Pa.

He began his career as a general practitioner before studying in his specialty at the Mayo Clinic in Rochester, Minn., and at clinics in Chicago and Ann Arbor.

During World War I he organized the Michigan Knights Templar Ambulance Company and became director of field hospitals in the 84th division. He was honored by the Michigan State Medical Society in 1957 as a 50-year member.

D. P. Philips, M.D., Lansing

David Patterson Philips, M.D., retired Lansing phychiatrist, died Dec. 14 at the age of 76.

Doctor Philips retired in 1962 after 50 years service as a psychiatrist. He was a graduate of the Ohio State University Medical School and was licensed to practice in Ohio, Illinois and Michigan. He served with the Department of Corrections of the State of Michigan.

A veteran of World War I, Doctor Philips had served with the U.S. Army Medical Corps. He was a life member of the Michigan Probation Prison and Parole Association.

C. F. Wible, M.D., Sebewaing

Charles F. Wible, M.D., Sebewaing physician for 18 years, died Dec. 4 at the age of 46.

Doctor Wible was past president of the Huron County Medical Society, former Federal Aviation Agency medical examiner and public health officer for Sebewaing.

He was graduated from Indiana University Medical School in 1950 and was affiliated with Bay City General Hospital as a general practitioner. He was a veteran of World War II. A pilot, he organized the Sebewaing Aero Club.

MAILBAG

More Than Just Nostrums In This Country Doctor's Bag

(Editor's Note: The December issue carried an editorial by E. Marshall Goldberg, M.D., Flint, about changes in medical practice. His references to "the country doctor with his bag chock full of nostrums . . . " drew the following letter from a Saginaw physician:)

As the son of, (not exactly) a country doctor, (he practiced for over half a century servicing the citizens of Saginaw City and surrounding country), I resent the implication that "the country doctor had his bag chock full of nostrums." As a young boy, I accompanied my father on many a lonely horse drawn cutter or buggy trip over snow drifted or muddy roads, one call often requiring the better part of a night. I don't know exactly what he had in his bag but I am sure it contained digitalis and quinine, and salicylates and colchicine, and belladonna and paregoric and chloroform so he could reduce a strangulated hernia and morphine and atropine to help pass a stone. These I wouldn't class as nostrums, and we still use these very drugs today. He didn't have antibiotics, or penicillin, but if he did I doubt if he would use them as indiscriminately as they are being used today, a nostrum device in my book.

I agree that these country doctors were "venerable gentlemen," and I wonder if the public's impression of today's ultra-scientific physician will be so recorded in history a half century hence.

I wonder also if we cure any less rarely now or if it is nature that cures most, and I wonder finally if we really comfort as much as we could.

— Richard S. Ryan, M.D.
Saginaw
12/28/68

Praises Medical Assistants

"The medical assistant is one upon whom the practicing physician depends to a great extent for the efficient running of his office. I believe every physician should encourage his assistants to become active members of the Society and to participate in its efforts to upgrade the standards of its members."

— Milford O. Rouse, M.D.
To AMA House

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization[1] — provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste — confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[2]

Concomitant relief of G. I. gas distress — provided by the proven antiflatulent action of simethicone[3].

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonsful to be taken between meals and at bedtime, or as directed by physician.

References: 1. Merck & Co., Merck Chemical Division: Antacid Literature Survey, Rahway, New Jersey. (MM3041, R-1286-K REV 463.) 2. Danhof, I.E., report on file. 3. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

DON'T BE A DOCTOR DROP-OUT!

ATTEND THE CHICAGO MEDICAL SOCIETY

MIDWEST CLINICAL CONFERENCE

March 2-5, 1969

Palmer House, Chicago

A "MUST" Meeting For All Physicians

MARK YOUR CALENDAR!

ACHROMYCIN® V
TETRACYCLINE

Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

359-8

Suspected tetracycline-sensitive infection?

While waiting for the results of the sensitivity test, start the therapy likely to succeed...

Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

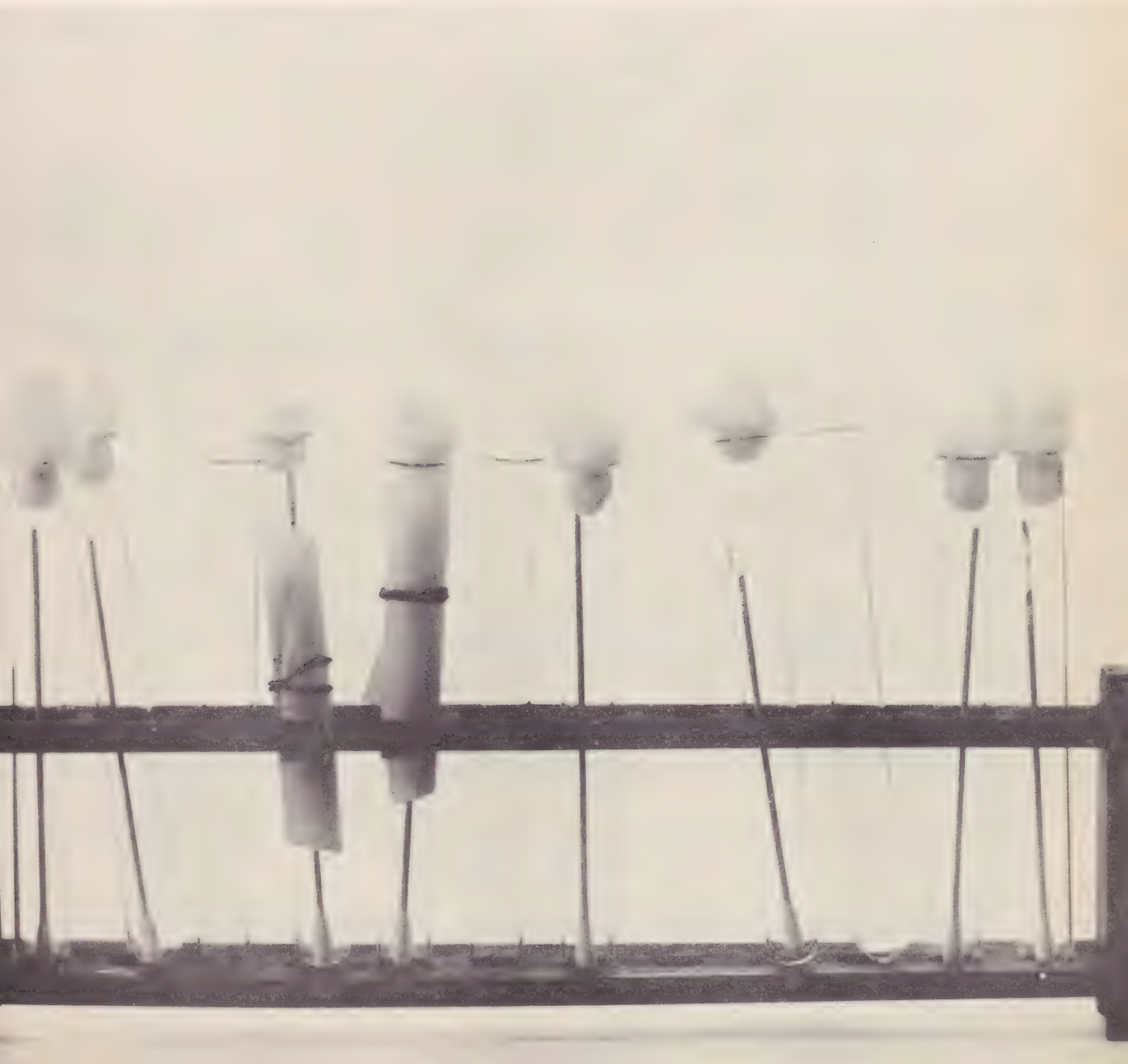
Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

←Prescribing Information

ACHROMYCIN® V
TETRACYCLINE

Lederle

The price differential is inconsequential.



Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

PSYCHIATRIC RESIDENCIES: Approved Three-year community oriented dynamic program in Metropolitan Detroit area. University associations. Teaching staff of Board men, psychoanalysts, professors, outstanding visiting lecturers. Active research. Modern physical plant. Salary $9,875; $10,445; $11,234. Five year career program $11,234 to $20,357. Liberal Civil Service benefits. Physicians completed internship four years ago may be eligible for NIMH stipends of $12,000 per year. Write: Director of Education and Research, Northville State Hospital, Northville, Michigan 48167.

GENERAL PRACTITIONER wanted. Top income immediately, no investment, no placement charge, hospital privileges assured. Ample office building owned by four GP partnership, with one retiring and another reducing practice. Southern Michigan city of less than 100,000 with golf, fishing, sailing and hunting nearby. On call one weekend in three. This ad is placed by the oldest management firm in the country. Write P.M. - B.C., Professional Management Associates, Incorporated, 181 North Avenue, Battle Creek, Michigan 49017.

MEDICAL DIRECTOR—Single County Health Department; population approximately 165,000. Department has 40 full time employees. V.D., T.B., and general health programs being followed. Good relations with local physicians. Excellent recreational and school facilities available. If under age 50, M.D., M.P.H. required. Over 50, 9 weeks of special training required within 3 years in lieu of M.P.H. Salary range $23,000 to $27,500, depending on qualifications and experience. Many fringe benefits. Send resume to James V. Wells, Chairman, Muskegon County Board of Health, County Building, Muskegon, Michigan 49440.

WANTED: Psychiatrist: Boards not mandatory; preferably under 40 years of age; Michigan license; to join 3-man private psychiatric group practice associated with private Psychiatric Hospital. Liberal salary first year, partnership later. Reply with autobiography. Box 332, Plainwell, Michigan 49080.

PSYCHIATRIC RESIDENCIES: Starting July 1969. Approved training in a mental institution with State of Michigan, Department of Mental Health. There are five year programs available. Salary $9,876-$11,233 and $11,254-$21,381. NIMH-GP stipends $12,000. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. For additional information, contact Dr. Paul Kauffman, Training Director, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

OPPORTUNITY FOR ORAL SURGEON. Only oral surgeon downtown, retiring from long established practice. All furnishings, equipment, records, three operatories, X-ray. Across from State Capitol, modern office, air-conditioned, reasonable rent. Easy terms, nothing down. Available in Spring. Contact Dr. B. E. Luck, 1512 Michigan National Tower, Lansing, Michigan (517) 484-3225.

INTERNIST — Board Certified or eligible. 269-bed General Medical and Surgical Hospital in Michigan's Upper Peninsula. Licensure any state, salary dependent upon background and qualifications. Excellent benefits for retirement, vacations, sick leave, and professional improvements. Non-discrimination in employment. Contact: Chief of Staff, VA Hospital, Iron Mountain, Michigan 49801.

GENERAL SURGEON: Board Certified or Eligible; 269 bed, General Medical and Surgical Hospital in Michigan's Upper Peninsula. Licensure any state, salary dependent upon background and qualifications. Excellent benefits for retirement, vacations, sick leave, and professional improvements. Non-discrimination in employment. Contact Chief of Staff, VA Hospital, Iron Mountain, Michigan 49801.

FOR RENT: Office space in modern professional building on Lansing's far west side. Air conditioned with off street parking. Hospitals in city easily accessable from this location. Rent reasonable, other occupants a G. P. and a dentist. Phone 482-9440 area 517.

WANTED: Two general practitioners to join two general practitioners in a large well-established practice of over 30 years in a town with population of 800 and covers large rural area of approximately 5,000. Location is 50 miles north of Minneapolis, Minn. in excellent hunting and fishing area with golf, bowling and other recreation also available. Have local community hospital, Medicare approved and equipped for general medicine and major and minor surgery. Salary negotiable, partnership available. New clinic planned. For references contact Dr. Gerald Larson, Cambridge Minnesota, Dr. Joe Halpin, Rush City, Minnesota; Dr. Richard Varco, Dept. of Surgery University of Minn. Medical School, Minneapolis, Minnesota; Dr. Dean Rizer Internist, Medical Arts Bldg., Minneapolis, Minnesota; Dr. Paul Larson, OB-Gyn, Medical Arts Building, Minneapolis, Minnesota. If interested send application and references to Braham Clinic, Attn: Wm. T. Nygren, M.D., Braham, Minnesota 55006, or phone area code 612-396-3355 between hours of 10-12 A.M. or 1-5 P.M. Monday thru Friday. If after hours phone 612-396-2153. May call collect. If acceptable, expenses for personal interview will be allowed.

GP MICHIGAN — Join GP and surgeon; growing community near Detroit, $22,000 first year, excellent facilities and hospitals, excellent opportunity, excellent recreational facilities, churches and schools available, rotate nights and week-ends, fringe benefits, opportunity for association after second year. If interested, Contact C. F. Gonzalez, M.D., St. Clair, Michigan, or call 329-4744 Area (313).

University Health Service: State University in Central Michigan seeking competent physician to complete staff. Present staff congenial. Pleasant working conditions. New facility to open in fall. Easily accessible to cultural and recreational center of Michigan. 12 Months contract with excellent fringe benefits. Salary competetive. Russell Ragan, M.D., Director Student Health Service, Central Michigan University, Mt. Pleasant, Michigan 48858.

Index to Advertisers
They Help Make Michigan Medicine Possible

Brown Pharmaceuticals 169
Burroughs-Wellcome 112
Chicago Medical Society 182
Classified Advertising 184
Geigy Pharmaceuticals 98, 99, 174, 175, 176
Hynson, Westcott & Dunnings, Inc. .....Cover II
Ingram, G. A. Co. 145, 152
Lederle Laboratories 94, 109, 110, 148, 165, 170, 182, 183
Lilly, Eli & Co. 118
Loma Linda Foods 106
McNeil Laboratories Inc. 149
Medical Arts Supply 141
Medical Protective 185
Mediclinics 148
Mercywood Hospital 169
National Drug Company 152, 171
Parke-Davis & Co. 111
Pitman-Moore Div., Dow Chemical Co. ...116, 117
Plainwell Sanitarium 147
Poythress, Wm. P. & Co. 148
Purdue Frederick Company 96
Robins, A. H. & Co. 107, 161, 162, 163
Roche Laboratories .....102, 103, Cover IV
Roselawn Manor 170
Searle, G. D. & Co. 150, 151
Smith, Kline and French Laboratories .....Cover III
Stratton, Ben P. 108
Stuart Co., The 181
Winthrop Labs 113
Wyeth 114, 115

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

DETROIT OFFICE: G. A. Triplett, R. K. Wind and J. K. Galloway, Representatives
27200 Lahser Road, Southfield 48075 Telephone: (Area Code 313) ELgin 3-4848 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative
422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477

NOTES & QUOTES

BY HERB AUER, EXECUTIVE EDITOR

A recent Illinois Hospital Association survey revealed that 61 of 211 responding hospitals have physicians as voting members. An additional 49 hospitals have physicians ex officio but without vote on their boards.

The MSMS House of Delegates several times has adopted resolutions urging hospitals to include one or more physicians as voting members. No complete Michigan statistics are available.

* * *

Eighty-five percent of the Michigan independent businessmen in a recent poll advocated a change in the federal minimum wage laws to allow lower rates of pay to



teen-agers, the handicapped, and the elderly. Thirteen percent were opposed to the proposal and two percent were undecided. The National Federation of Independent Business contends that many owners cannot afford to pay the dictated $1.60 an hour rate plus fringe benefits for unskilled, inexperienced help.

* * *

Looking back in the two-volume **Medical History of Michigan** published in 1930 by MSMS, one will find many comments about "tobaccoism." The medical history books, edited by C. B. Burr, M.D., include a statement made in the early 1900's by J. H. Kellogg, M.D., of Battle Creek. Doctor Kellogg (1852-1943) in his article about "Plain Facts about Sexual Life" in the **Detroit Lancet**, wrote: "Few are aware of the influence upon morals exerted by that filthy habit, tobacco using. When acquired early it excites the underdeveloped organs, arouses the passions, and in a few years converts the once chaste and pure youth into a veritable volcano of lust, belching out from its inner fires of passion torrents of obscenity and sulphurous fumes of lasciviousness."

* * *

Pharmaceutical manufacturers, who formerly had about 200 medical publications to choose from, now can run their ads in over 400 journals. More and more, medical journals are being established by the growing number of specialty associations. In the past decade there has been a tendency for firms to advertise specific drugs in specialty journals going to the interested specialists.

The MSMS Publication Committee appreciates the practice of many Michigan physicians to tell drug detail men that their ads are read in *Michigan Medicine*. *Michigan Medicine* continues to merit advertising support because it carries quality scientific articles and socio-economic material with strong Michigan flavor.

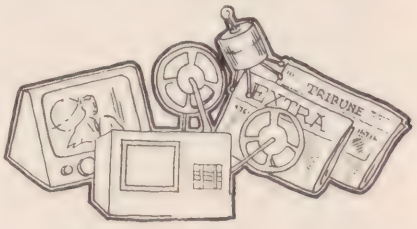
* * *

New federal Vocational Education Amendments of 1968 are beginning to make an impact on training programs for health workers. "Only 1.5 percent of the vocational students in 1967 were enrolled in health occupation programs," reports the U.S. Office of Education, "but the 1968 figures should be 15 to 20% greater than 1967; and far greater in 1969."

A special committee of the Michigan Legislature is examining present state laws which cover transplantations. The MSMS point of view will be similar to those expressed by an AMA spokesman before the GOP Convention Platform Committee. Donald E. Wood, M.D., Chairman of the AMA Council on Legislative Activities, declared in part: "Recent heart transplants are but one indication of the vitality of medical research and practice, a vitality that responds to the energies and intelligence of free men working in a society that stimulates thought and action."

* * *

Changes in the nation's power structure were recently discussed by *Detroit News* publisher Peter B. Clark. He said, "The most



significant new power categories are (1) college professors, (2) career government officials, and (3) journalists." He added that, "The basis for the new power is information, not money or force."

* * *

Physicians in many Michigan communities are helping local Jaycee chapters in their current "Operation Opportunity" projects. Michigan's Wendell Smith, president of the U.S. Jaycees, explains the current Jaycee voluntary community projects by observing, "We have seen the systematic failure of Federal poverty programming, a rise in crime and violence stemming from unbelievable conditions in the innercity and a general loss of hope among these oppressed Americans."

* * *

Physicians can help their service club friends learn more about the voluntary efforts of physicians in South Vietnam by showing the new AMA film, "Bac Si My." The 13-minute color film is available from the AMA, 535 N. Dearborn, Chicago 60610.



Ornade®

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

Ornade® Spansule® capsules

Trademark Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

brand of sustained release capsules

Smith Kline & French Laboratories SK&F

Return Postage Guaranteed

MICHIGAN STATE MEDICAL SOCIETY
120 W. Saginaw
East Lansing, Michigan 48823

MJ
NATL LIB OF MEDICINE
8600 WISCONSIN AVE
[illegible] 14 MD 20014

Symbols in a life of psychic tension

B.A.
cum laude

V.P.
at thirty-two

ECG
and complete examination normal
(persistent palpitations)



Valium®
(diazepam)

for reliable relief of psychic tension and associated somatic and depressive symptoms (including tension-induced insomnia)... usually well tolerated... 2-mg, 5-mg or 10-mg tablets *t.i.d.* and *h.s.*

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

FEBRUARY, 1969 • VOLUME 68 • NUMBER 4

NATIONAL LIBRARY OF MEDICINE
RECD. MAR 1 1 1969
INDEX
INPUT

MDs, DOs WOULD TAKE SAME TEST

Single Medical Practice Act Introduced To Improve Standards of Health Care

The Michigan legislature will consider a bill in this session to increase the protection given to the public for quality medical care.

The Michigan State Medical Society is supporting a Single Medical Practice Act proposal that would set up one high standard of medical care for both the doctors of medicine and the doctors of osteopathy.

Two legislators on February 17 asked that a bill be drafted. Many others will sign as co-introducers.

"The new Single Medical Practice Law has the protection of the public as its primary purpose," explained Ross V. Taylor, M.D., MSMS Council chairman. The proposed bill offers improved disciplinary provisions and these also would help insure high standards of ethics and performance, Doctor Taylor added.

"SINCE THERE IS ONLY ONE scientific basis for modern medical care, it seems appropriate that there be only one set of standards and one examination under a single licensing board," Doctor Taylor told a news conference February 17.

"In this proposed law, doctors of medicine recognize the ethics and standards of both groups as similar, and have provided identical licensure requirements so that the public will know that both disciplines — in order to practice unrestricted medicine — do meet the same high standards," John J. Coury, M.D., Chairman of the MD-DO Committee, told reporters.

DOCTOR TAYLOR SENT a copy of the proposed bill to the president of the Michigan Association of Osteopathic Physicians and Surgeons inviting their support.

Doctor Taylor said, "We are inviting and will welcome osteopathic support for this bill. We see no reason why osteopaths will not support this bill that will apply equally to MDs and DOs and will be in the interest of the public. The law will permit all physicians to demonstrate their competence by meeting the same standards in the same test at the same time — and still be licensed as either a MD or a DO."

MSMS officials urge doctors of medicine to explain the advantages of this bill with legislators, osteopathic physicians, hospital administrators, and others. The full bill will be printed in the March issue of *Michigan Medicine.*

THE BILL CALLS for a single State Medical Board on which both MDs and DOs would serve according to the number of each within the state — as is presently done in 20 states. Such a board in Michigan would include two doctors of osteopathy and eight doctors of medicine, the present licensure ratios in the state. As of December 31, 1967 there were 1,642 osteopaths and 9,590 doctors of medicine, providing patient care in Michigan, according to HEW.

The bill provides that the Michigan Association of Osteopathic Physicians and Surgeons and the Michigan State Medical Society would nominate members for the governor to consider as Board appointees. The two professional societies, as outlined in the bill, would "suggest not less than three times the number of appointments to be made." The Board members, to be named on a staggered basis, would serve four-year terms.

THE NEW BILL would give the State Board of Medicine new options for disciplinary action. The Board could place a physician under probation and give him only a limited, supervised license.

The proposed law also gives the Board new power to deal with alleged felons who have been found guilty in a first court while

(Continued on 188)

Second Annual Health Planning Conference Set
SEE PAGE 188

Second Annual Health Planning Conference Set for April 16-17 in Kalamazoo

Plans are well underway for the Second Annual Michigan Conference on Health Planning and Related Subjects to be sponsored by MSMS, April 16 and 17 at the Student Center, Western Michigan University in Kalamazoo.

Between 150 and 200 persons are expected to attend the conference, which is open to any MSMS member and will run contiguous to and including the traditional Officers' Conference.

The statewide meeting is being planned to develop the MSMS belief that private physicians and the private voluntary health planning segment should recognize the existence of government planning in the field and try to participate in it as needed.

"Health planning is important to all health professionals and those interested in health," reminds Hugh W. Brenneman, MSMS executive director. "Both the government and the private individual or voluntary organization take part in health planning.

"But the planning done by the private volunteer organization and individual is far more important to the total services rendered to the public than that done by the government and their experience is far greater, too, in aggregate health planning."

Speakers, who will be announced later, will represent the AMA, state government, Michigan's medical schools, MSMS, Blue Cross, Blue Shield and business agencies.

Below is the general plan for the two-day conference:

Wednesday, April 16

Morning: Governmental health planning, its operations, structure and functioning on the national, state and local level, including a brief history of governmental health planning legislation. MARMP will be included in discussions.

Noon: A major speaker is scheduled with a topic to bridge the gap between the morning and afternoon discussions.

Afternoon: Health Planning by volunteer organizations and the private physician, including discussion of coordinating efforts of citizens to get more health manpower. A major speaker will describe how the individual may influence medical education and manpower through working with the legislature.

Evening: Reception and dinner

Thursday, April 17

Morning: The economics of medical practice, with an opportunity to see the effects of legislation and physician protection policies on medical practice, as well as a description of the operations of county and state medical societies.

Noon: Speaker

Afternoon: The entire executive and senior staff of MSMS will be available in an informal setting for questions and answers on the day-to-day operations and financing of the organization, legal problems and policies, legislation and political activities, educational and governmental programs, and insurance, Blue Cross and Blue Shield.

Continued from 187

they exhaust lengthy court appeal suits.

The drafting of the bill was requested by Senator Robert VanderLaan, Kent County, majority floor leader; and by Representative William Hampton, Oakland County, minority floor leader.

The MSMS House of Delegates in 1964 first authorized preparation of such a possible bill. Progress reports were reviewed each year since and last fall the policy-making House of Delegates authorized the appointment of a committee to review the final draft of a bill. **(See photo of committee, page 189.)**

MSMS HAS HAD a progressive and liberal attitude regarding osteopaths for some time. Qualified osteopaths are invited to the annual scientific meeting and clinical conferences. Osteopaths are invited into associate membership in the county medical societies and the state society. MSMS has had the position for several years that it is appropriate for qualified DOs to serve on MD hospital staffs — at present some 35 Michigan medical hospitals do have osteopaths on their staffs. A single medical licensure law, pointed out Doctor Taylor, will simplify procedures so hospitals may have combined MD-DO staff appointments.

Mark Your Calendar Now . . .

104th Annual Scientific Session
Michigan State Medical Society
Detroit, October 1-2

Maternal Welfare Conference Program Includes Two Michigan Doctors

Doctors attending the Eighth Annual Michigan Conference on Maternal and Perinatal Welfare March 26-27 in Flint will hear two Michigan physicians who are veterans of years of experience in their particular fields.

Robert D. Visscher, M.D., Grand Rapids, has been working since May, 1967, with two other Grand Rapids doctors on the prevention of Rh Isoimmunization with Rh Immune Globulin, and has been engaged in clinical research in Grand Rapids for six years.

The title of his talk is, "Who Should Receive Rh Immune Globulin?"

Doctor Visscher is project director for the two-year-old study of Rh Isoimmunization which is being carried on in three Grand Rapids hospitals — Butterworth, Blodgett Memorial and St. Mary's. He is senior attending physician at Blodgett Memorial Hospital and co-director of education in research, obstetrics and gynecology at St. Mary's Hospital.

Doctor Visscher will talk about the background and history of some of the findings leading up to the three-part study, the study itself, who should receive Rh immune globulin, what the dose should be, what the failure rate is and why, and what the side effects are.

Colin Campbell, M.D., Ann Arbor, will discuss "Amniotic Fluid Analysis and Intrauterine Transfusion in the Management of Erythroblastosis Fetalis."

Doctor Campbell, associate professor of obstetrics-gynecology, Department of Obstetrics-Gynecology, University of Michigan Medical School, is on a team of three doctors at the U. of M. who have done one of the world's largest series of intrauterine transfusions. The Rh team's experience constitutes 10 per cent of the world's experience in intrauterine transfusions.

The three doctors are in the process of compiling their experiences in written form and have been the subjects of a film.

DRUG THERAPY OF HYPERTENSION SYMPOSIUM TOPIC

The Hypertension Clinic of Edward W. Sparrow Hospital and the Michigan State University College of Human Medicine will cosponsor a symposium for practicing physicians titled "The Drug Therapy of Hypertension" March 12 and 13 at Kellogg Center, East Lansing.

The one-and-a-half-day program will offer physicians an opportunity to discuss the basic pharmacology and clinical use of drugs in the treatment of hypertension. Included will be lectures, panel discussions and informal consultations with Harriet Dustan, M.D., Cleveland Clinic; Roger Heckler, M.D., Harvard Medical School; Mark Nickerson, M.D., McGill University and John Weller, M.D., University of Michigan Medical School.

The symposium, which will include an elective program on the interpretation of the rapid sequence IVP and renal angiogram, is being sponsored through a grant from the Michigan Association of Regional Medical Programs.

STROKE CARDS IN MARCH ISSUE

The March issue of *Michigan Medicine* will carry a revised set of the series of "Stroke Cards" prepared by the Michigan Heart Association. Printed on heavy, blue card stock, and perforated for easy removing from the magazine, the cards are designed to be torn out and kept for handy reference in an index file.



The committee charged with the important task of drafting the MSMS Single Medical Practice Bill and studying all its ramification includes standing, from left, Frederick Van Duyne, M.D., Flint; Frederick S. Gillett, Grand Rapids; Otto K. Engelke, M.D., Ann Arbor, and Charles W. Cory, M.D., Saginaw. Seated from left are Don W. McLean, M.D., Detroit; James Fryfogle, M.D., Southfield; James R. Quinn, Jr., M.D., Bloomfield Hills; F. C. Brace, M.D., Grand Rapids, and John G. Slavin, M.D., Grosse Pointe Park.

Team Physicians, Coaches To Confer at MSU, May 8

All MSMS members, and team physicians especially, are invited to participate in the 1969 MSMS Conference on the Medical Aspects of High School Sports at Michigan State University, Thursday, May 8.

Several hundred physicians, high school coaches, trainers and interested school administrators are expected for the fourth annual spring conference.

The MSMS Committee on Medical Aspects of Organized Athletics met February 6 to complete the plans for the program.

The all-day conference will feature the following topics:

Knee Injuries
Taping
Protective Equipment
Wrestling Weight Problems
Psychology of Coaching
And other subjects.

The program will begin at 9:30 sharp at the Kellogg Center on the MSU campus where there is plenty of parking. The only charge will be $3.00 for the luncheon.

Speakers will include outstanding team physicians and trainers from Big Ten universities and from several medical schools.

A complete program and registration blank will appear in the March issue of the *Michigan Medicine* News Extra.

Cosponsoring the event with MSMS will be the MSU College of Human Medicine, Student Health Center, and Continuing Education Service.

G. A. O'Connor, M.D., team physician for the University of Michigan, is the committee chairman. James S. Feurig, M.D., team physician for the Spartans, is the conference program chairman.

Did You Read?

Doctors, did you read the important and excellent article on "The Future of Private Practice: Salvation at the Grassroots" that appeared on pages 119-129 in February's issue of *Michigan Medicine*?

The article, written by Lewis A. Miller, editor of *Patient Care* magazine published in Stamford, Conn., is one of a series on medicine's future commissioned by the MSMS Committee on Medical Socio-Economics.

MAGP Postgrad Clinic Expects 800 Doctors, March 12-13

Approximately 800 doctors are expected at the 23rd annual Postgraduate Clinic of the Michigan Academy of General Practice, March 12-13 at the Sheraton-Cadillac Hotel in Detroit.

The clinic will feature five concentrated clinical courses, or "wet clinics" offering instruction in depth with live patients, talks by 24 speakers and 32 scientific exhibits.

Topics of the "wet clinics" scheduled from 3:30 to 5:30 p.m. March 13 will be multiple sclerosis, arthritis and rheumatism, frequently-encountered mental disorders, skin cancer and smoking and health. Henry Krystal, M.D., Detroit, will lead the clinic on frequently-encountered mental disorders.

Following is a time schedule of the meeting, giving general topics.

WEDNESDAY, MARCH 12

9 to 11 a.m., Psychiatry and Neurology

11 a.m. to noon, General Medicine

1 to 2:30 p.m., panel on O.B. Complications

3:30 to 5:30 p.m., General Medicine

THURSDAY, MARCH 13

9 to 10 a.m., Geriatric Medicine and Urology

11 a.m. to noon, Psychiatry

1 to 2:30 p.m., Directors of "Wet Clinics"

3:30 to 5:30 p.m., Instruction In Depth

Michigan Medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at Lansing, Michigan. Yearly subscription rate, $9.00. Printed in USA. All communications should be addressed to Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.
© 1969 Michigan State Medical Society.
Phone: Area Code 517, 337-1351.

MJ
NATL LIBR OF MEDICINE
8600 WISCONSIN AVE
BETHESDA 14 MD 20014

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

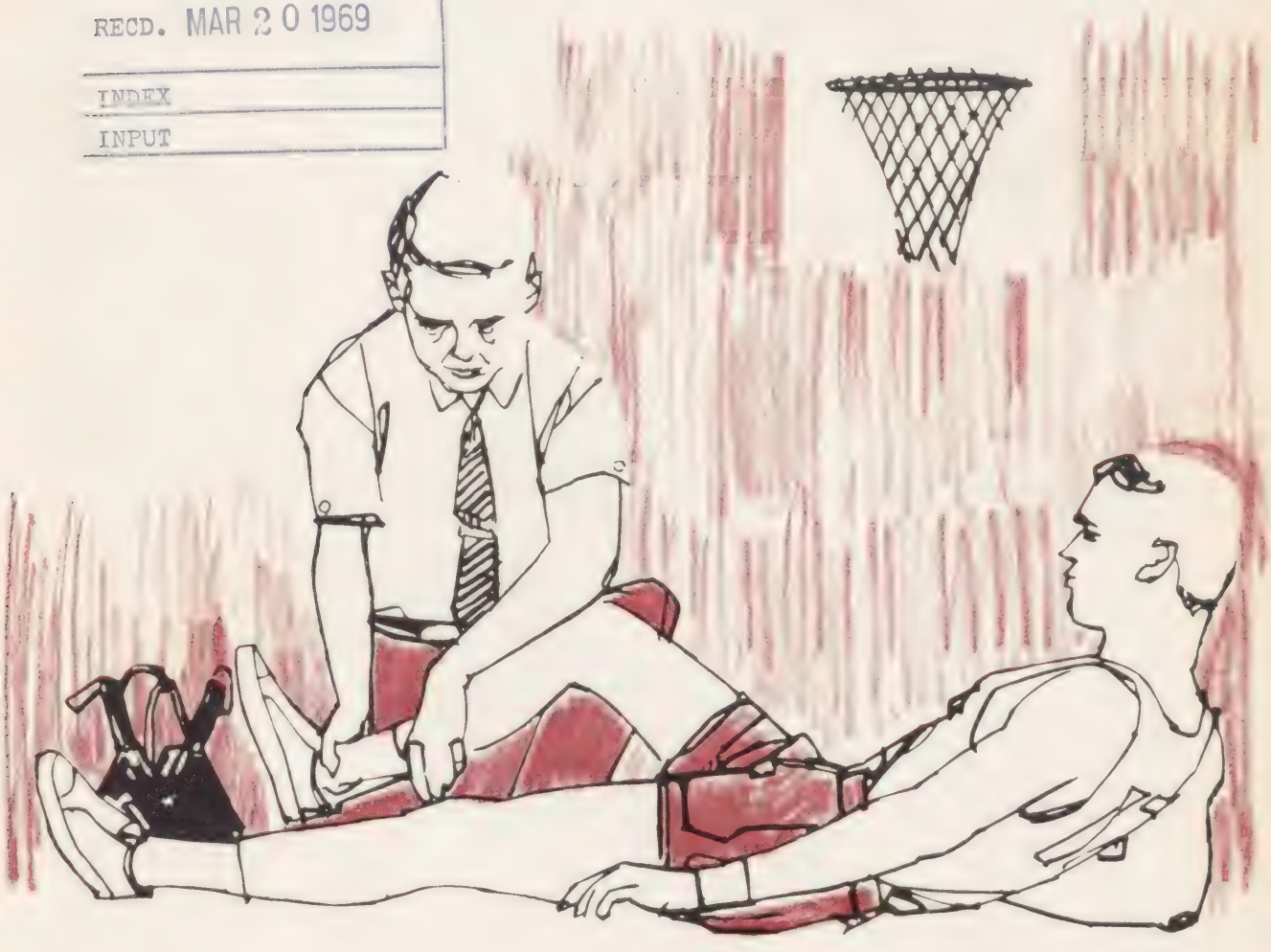
Michigan Medicine

MARCH, 1969 • VOLUME 68 • NUMBER 5

ALL MSMS MEMBERS ARE INVITED TO PARTICIPATE IN THE FOURTH ANNUAL CONFERENCE ON MEDICAL ASPECTS OF HIGH SCHOOL SPORTS AT MSU MAY 8 □ SEE DETAILS INSIDE □ READ ALSO ABOUT ENTIRE TEXT OF SINGLE MEDICAL PRACTICE ACT □ MYOCARDIAL INFARCTION DURING HYPERTHYROIDISM □ QUESTIONS AND ANSWERS ABOUT MARMP □ QUACKERY THEME OF PRESIDENT'S PAGE

JTC:
VOL-
DATE:
DEPT:
NON-JAPAN:
RUSH:
SELECTIVE:

NATIONAL LIBRARY OF MEDICINE
RECD. MAR 20 1969
INDEX
INPUT



LACTINEX®

TABLETS & GRANULES

- **to help restore and stabilize the intestinal flora**
- **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(LX-05)



References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

MARCH, 1969 • VOLUME 68 • NUMBER 5

See Table of Contents For This Issue, Page 197

MSMS POSITIVE PROGRAM INCLUDES OPTIONAL DEGREE PROPOSAL

Better Answers Available to Solve MD Shortage Than Possible School to Train Only Osteopaths

BY M. A. RILEY
LEGISLATIVE COUNSEL

MSMS members are requested to discuss with their legislators the reasons why SB-70 (to establish an osteopathic state college) should not be passed.

On January 30, Detroit Senator Raymond Dzendzel, chief introducer of a similar unsuccessful bill in 1965-66, again introduced a "Michigan Osteopathic College Authority" proposal in the State Legislature. The nearly identical bill of four years ago was defeated three consecutive times, by votes of 54 to 39 (two short of passage) — then 44 to 27 (twelve short) and finally 49-47, or seven votes less than needed to pass.

SB-70 has 14 introducers this year and it takes 20 votes to pass the bill in the Senate. Four years ago the DO school bill, with 26 introducers, easily cleared the Senate but failed in the House.

SB-70 WOULD MAKE an Osteopathic College Authority a state agency; its board of control (of 8 members) would be selected completely from recommendations of the Michigan Osteopathic Association, and the board would be completely autonomous.

The bill says that the State of Michigan shall pay all the college's bills.

Any proposed osteopathic college has not been authorized by the Board of Education, while MSU has been supported by that Board and the Governor as Michigan's third medical school.

THE BILL'S PROPONENTS (and DO lobbyists) are "merely" asking for the State to "bless" an Authority this year — without requesting funds. It should be obvious that the fund requests will hit hard, in succeeding years, diverting a probable 30-40 million dollars from Michigan's medical schools (if an institution of the size the DOs are discussing now should materialize.)

MSMS has recommended to the State Board of Education that the three medical schools be expanded — and any fourth or fifth schools — give students the choice of either the MD or DO degree.

THE STATE BOARD of Education has flatly stated that any medical school must have a "meaningful affiliation" with a full university, and the proposed DO school has no affiliation with any university, even a tenuous one.

The deans and presidents of U-M, WSU, MSU have indicated that it is feasible to offer curricula in all three schools leading to an optional DO degree. This sort of program, coupled with the sizeable increase in the three entering classes could be achieved more economically than to appropriate the millions of dollars required for a DO college.

MANY MICHIGAN Legislators, both Senators and Representatives, inform MSMS interviewers that they are watching with great interest the practical effect of the MSMS liberal and progressive positions on osteopaths generally. Much interest has been expressed in the actual number of DO associate members in the State Medical Society, and in the actual number of osteopaths who have been accepted on MD hospital staffs, as well as the extent of hospital privileges granted these practitioners.

It is important to make it clear to legislators that MSMS offered "associate" membership in Michigan while it was urging full membership for qualified DOs in AMA National councils. Largely because of the threat of ostracism, few

Be Sure to Read, Study Single Medical Practice Act, Page 240

May 8 Chosen For Medicine, Religion Meeting

May 8 is the date set for the Annual MSMS-sponsored Medicine and Religion Workshop. Representatives have been invited from all county medical societies for the 10 a.m. to 3:15 p.m. meeting.

The major speaker will be Paul B. McCleave, LL.D., of the AMA Medicine and Religion Committee. The new AMA film, "A Storm, A Strife," will be shown.

The meeting will be chaired by Winslow G. Fox, M.D., Ann Arbor, chairman of the MSMS Committee on Medicine and Religion.

Early plans for the Medicine and Religion Workshop planned in May were made in February when members of the MSMS Medicine and Religion Committee met with Carl H. Peterson, Jr., second from right, assistant to the AMA director of medicine and religion. Others, from left, are W. C. Beets, M.D., Grand Rapids; J. S. Kozak, M.D., Lansing, and Winslow G. Fox, M.D., Ann Arbor, chairman of the MSMS committee.



Better Answers Available to Solve MD Shortage Than Possible School to Train Only Osteopaths

Concluded from Page 191

Michigan DOs have accepted associate membership in their county medical societies and MSMS. But it is highly significant to point out that in a relatively short time, thirty-six (36) Michigan medical hospitals have accepted DOs on their staffs.

SB-70 HAS BEEN referred to the Senate Education Committee for initial consideration. Membership of this Committee is: Republican Senator Anthony Stamm, Kalamazoo, Chairman; Republican Senators Bursley of Ann Arbor and VanderLaan of Grand Rapids, and Democrat Senators Young of Detroit and Gray of Warren.

A companion to SB-70 has been introduced in the House by Rep. Josephine Hunsinger, Detroit Democrat and new chairman of the powerful House State Affairs Committee. The bill has been sent to the Appropriations Committee. The Committee includes Democrat, Rep. Wm. Copeland, Wyandotte, chairman; Democrats Jacobetti of Negaunee, Faxon of Detroit, Hellman of Dollar Bay, Huffman of Madison Heights, Kehres of Monroe, Kildee of Flint, Law of Pontiac, Montgomery of Detroit, Snyder of St. Clair Shores, and Stempien of Livonia, and Republicans Farnsworth of Plainwell, DeStigter of Hudsonville, Ford of Grand Rapids and Smith of Ypsilanti.

1969 Legislative Schedule

The 1969 schedule for the Michigan Legislature is as follows:

February 17 — final day for requests for bills (except by appropriations committees) for the 1969 regular session.

March 17 — final day for introduction of bills, except appropriations.

April 18 — final day for committees to report bills of their own House.

May 28 — final day for committees to report bills originating in the opposite House.

May 29-June 2 — recess.

June 13 — final day for passage of bills originating in the opposite House.

June 21-July 29 — recess.

July 22-23 — conference committees.

Fourth Annual School Sports Conference To Include Psychology of Coaching

"Psychology of Coaching" will be one of the new subjects for the Fourth Annual MSMS Conference on the Medical Aspects of High School Sports, at MSU, May 8.

All team physicians, high school coaches and trainers are invited to the Kellogg Center conference.

The MSMS Committee on the Medical Aspects of Organized Athletics met recently at the MSMS headquarters and selected five major subjects for study at the conference. The others will be "Knee Injuries," "Protective Equipment," "Wrestling Weight Problems," and "Taping."

G. A. O'Connor, M.D., team physician for the U-M Wolverines, MSMS committee chairman, invites MSMS members to come to the conference and to bring a high school coach, trainer or school administrator along. Doctor O'Connor praised the Ottawa County Medical Society for its project of sending two or three carloads of doctors and coaches to the annual conferences as both an educational and public relations effort. Last year at the Detroit conference, Ottawa had the largest delegation present. The 1966 and 1967 events were held on the U-M campus.

James S. Feurig, M.D., MSU team doctor, is the conference program chairman. He reports that a complete copy of the program will appear in the next issue of *Michigan Medicine*.

Every MSMS member is urged to read the proposed Single Medical Practice Act, printed in this issue on pages 242-243-244.

Two ranking legislators on February 17 asked that the bill be drafted, and an invitation was delivered that day with a copy of the bill to the president of the Michigan Association of Osteopathic Physicians and Surgeons requesting DO support.

MSMS members are urged to discuss the advantages of the proposed legislation with their lawmakers, local osteopaths, and others.

Michigan Doctors Take Part In MHA Scientific Sessions

Michigan doctors will be participants in the 20th Annual Scientific Sessions of the Michigan Heart Association scheduled April 11 and 12 at the Sheraton-Cadillac Hotel in Detroit. Cardiac Therapy is the theme of the two-day meeting.

Gerald M. Breneman, M.D., Detroit, and Ernest W. Reynolds, Jr., M.D., Ann Arbor, will be two of the four members of a panel planned for 3:20 p.m., Friday, April 11.

Doctor Breneman is associate physician, Department of Cardiology, and Head, Coronary Care Unit, Henry Ford Hospital, as well as chairman of the Michigan Heart Association's Coronary Care Unit Committee. Doctor Reynolds is a professor of internal medicine at the U of M Medical Center and teaches and researches in the fields of electrocardiography and cardiac arrhythmias.

Donald C. Overy, M.D., is chairman of the Friday, April 11, afternoon session on Coronary Care Units. He is a Pontiac cardiologist and chairman of the Scientific Sessions Committee of the Michigan Heart Association.

Michael C. Kozonis, M.D., is chairman of the Saturday, April 12, morning session on Coronary Artery Disease and will also give the official welcome. He is also a Pontiac cardiologist and is president of the Michigan Heart Association.

Edward W. Green, M.D., director of cardiology at Children's Hospital, Detroit, and president-elect of the Michigan Heart Association, is chairman of the Saturday, April 12, afternoon session on thromboembolism.

Clinical Genetics Series Ready at Oakland U.

The Fourth Medical Symposium Series on Clinical Genetics for Practicing Physicians will be conducted March 18 through May 6 at Oakland University near Pontiac. Sponsors include the Oakland County Medical Society, leading osteopathic physicians in the area and the University's Division of Continuing Education.

Doctors wishing further information on the weekly sessions, which will deal with basic information on new developments in the field of Human Genetics and their clinical applications, should write Department of Post Graduate Professional Education Programs, Division of Continuing Education, Oakland University, Rochester, Mich. 48063.

Council Re-elects MSMS Leaders

At its January meeting, The Council re-elected Secretary Kenneth H. Johnson, M.D., Lansing; Assistant Secretary Brooker L. Masters, M.D., Fremont; Treasurer John R. Ylvisaker, M.D., Pontiac; Assistant Treasurer C. Allen Payne, M.D., Grand Rapids, and Scientific Editor John W. Moses, M.D., Detroit.

The Council also reappointed Executive Director Hugh W. Brenneman and Associate Executive Director Warren F. Tryloff.

Second Health Planning Meeting To Include Variety of Topics

All MSMS members are invited to participate in the Second Annual Michigan Conference on Health Planning to be sponsored by MSMS at the Western Michigan University, Kalamazoo, April 16-17.

The conference will focus on health planning and related subjects. Held last year in Detroit, the event has been scheduled for the attractive Western Student Center.

"The conference is a continuing education service directed at the practitioner at the local level," stresses MSMS Council Chairman Ross V. Taylor, M.D. The conference will emphasize the Society's belief that private physicians and voluntary health planning organizations should participate effectively in government planning.

The program on Wednesday, April 16, will cover government health planning at all levels and its relationships to the private sector. MSMS members, hospital administrators and other health-related personnel are invited.

Thursday, April 17 will be reserved for county medical society officers and interested physicians. The program will include information on medical economics; legislation; liabilities, taxes and costs of private practice; how to reduce costs of providing medical care, and other subjects. Round table discussions about various MSMS projects and programs will be featured.

A complete program, listing national and Michigan experts as speakers, will be mailed to every MSMS member, and will appear in the March news extra of *Michigan Medicine.*

Here is Complete, Revised Program Of Flint Maternal Welfare Conference

The final, complete and revised program has been compiled for the eighth annual Michigan Conference on Maternal and Perinatal Welfare to be sponsored jointly in Flint March 26-27 by the Michigan State Medical Society and the Clara Elizabeth Fund of Flint.

This conference is acceptable for Category II credit by the American Academy of General Practice.

In order of their appearance, the speakers, their titles and topics, are as follows:

Robert D. Visscher, M.D., Grand Rapids, Senior Attending, Blodgett Memorial Hospital, Co-Director of Education and Research, Obstetrics-Gynecology Department, St. Mary's Hospital, "Who Should Receive Rh Immune Globulin?"

Colin Campbell, M.D., Ann Arbor, Associate Professor of Obstetrics-Gynecology, Department of Obstetrics-Gynecology, University of Michigan Medical School, "Amniotic Fluid Analysis and Intrauterine Transfusion in the Management of Erythroblastosis Fetalis."

Herbert S. Kupperman, M.D., Ph.D., New York City, Associate Professor of Medicine, New York University Medical Center, "Hormone Levels and Significance During Pregnancy."

Joseph W. Goldzieher, M.D., San Antonio, Tex., Director, Division of Clinical Sciences, S.W. Foundation for Research and Education, "Myths About Oral Contraceptives."

Alan F. Guttmacher, M.D., New York City, President, Planned Parenthood-World Population, "Sex Education and Family Planning."

John W. Huffman, M.D., Chicago, Ill., professor of Obstetrics-Gynecology, Northwestern University Medical School, Attending Gynecologist, Passavont Memorial Hospital, Emeritus Chief, Division of Gynecology, "Kindergarten Gynecology."

Murdina M. Desmond, M.D., Houston, Tex., Professor of Pediatrics, Head, Newborn Section, Department of Pediatrics, Baylor University College of Medicine, "Neurological Evaluation of the Newborn."

Bradley E. Smith, M.D., Miami, Fla., associate professor, Department of Anesthesiology, University of Miami School of Medicine, "Analgesics, Anesthetics, Potentiators Used — Pre and Intrapartum."

Doctor Pickett Named To Detroit Post

George Pickett, M.D., M.P.H., has been appointed commissioner of the Detroit-Wayne County Health Department.

The appointment was made by Mayor Cavanaugh upon the recommendation of the Detroit Board of Health and the Wayne County Health Department.

Doctor Pickett has been acting commissioner since the retirement last September of John J. Hanlon, M.D., who left to become deputy administrator of Consumer Protection and Environmental Health Services in Washington, D. C.



JAMES J. LIGHTBODY, M.D.
PRESIDENT, 1968-69

No Such Thing As A "Wise Quack"

We do not know where our usage of the word "Quack" originated but we at least have a modern explanation of our meaning as follows:

> "A Quack is one who fraudently misrepresents his ability and experience in the diagnosis and treatment of disease or the effects to be achieved by the treatment he offers."

There has been a great revival of interest in the field of medical quackery in the past few years mainly because of the increased number of individuals and organizations who are promoting highly questionable gadgets, devices and diet cures. Even books full of quackery have made the best seller list. The diseases most commonly exploited in this fraudulent field are cancer, arthritis, heart disease, nutrition and sex rejuvenation.

MEASURED ON A NATIONWIDE BASIS in terms of just plain fraud, these quacks take out of the pockets of gullible or desperate Americans more than 3 billion dollars annually. More money is wasted on phony cures than all the other confidence games and swindles put together. Measured in terms of death — it was reported to the Third National Conference on Medical Quackery that every year more Americans lose their lives to health quackery than to all crimes of violence.

The Michigan State Medical Society began its campaign against medical quackery at the First Annual Comprehensive Health Planning Conference in February, 1968, and this was followed in April by a full one-day conference on quackery at our headquarters.

At the April conference we brought together representatives from the Michigan Legislature, from law enforcement organizations, including the Attorney General's office of the State of Michigan, representatives from courts, Michigan Bar Association, from the news media, representatives from the Foundations and other health related organizations and from the medical profession.

WE MUST REMEMBER that only a small number of today's medical quacks are the old-fashioned lecturers and spielers. Today's frauds are much more sophisticated and often run special "clinics" outfitted with all the attractive gadgetry of a space-conscious nation.

Doctor James Goddard, United States Food and Drug Commissioner, has been taking a long hard look at quackery advertising — which was defined as twisting "healing" into "stealing." Useless gadgetry machines and contraptions, vitamin fakery and nutritional dishonesty are the tools that carry distorted claims of cures of all types of disease.

To control or eliminate this unhealthy business of quackery demands the interest of many individuals and organizations. Perhaps the place to start would be to review the present laws having to do with fraud to determine if they are adequately applicable to the problem of the modern-day quack. Several states have already done this and have passed appropriate legislation to assist the courts in the clamping down of questionable procedures in the health field. Cases that come to the attention of patients and physicians, or anyone else, should be reported so that we may accumulate a more accurate picture of these fraudulent treatments and alleged cures. In fact, there may still be a very small number of members of our own profession who operate by the use of "secret" medications and remedies particularly in relation to the treatment of patients with injectable materials.

After all, it is the person who has some physical complaints — or thinks he does — that falls prey to new remedies and money-making hoaxes that are constantly being devised to bilk the patient. While modern drugs and other legitimate types of treatment and therapy can help most patients, these valid treatments are not normally advertised in routine magazines, newspapers, radio or on television. There is no such thing as a "wise quack."

James J. Lightbody, M.D.



PRESIDENT'S PAGE



He is a diabetic.
He is middle-aged.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES

A Division of American Cyanamid Company, Pearl River, New York

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by **Michigan Medicine. Michigan Medicine** will pay the first $25 of the engraving bill, and the authors shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.

6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.

7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

8. Articles should ordinarily be less than four printed pages in length (3000 words).

9. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

10. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

Michigan Medicine

IN THIS ISSUE

SCIENTIFIC ARTICLES

209 **Myocardial Infarction During Hyperthyroidism; Robert C. Douglass, M.D., Myer Teitelbaum, M.D., Gerald J. Aben, M.D.**

213 **Trichophyton Violaceum; James D. Stroud, M.D., Jules Altman, M.D., Coleman Mopper, M.D.**

215 **Psychiatric Referral of a Pediatric Patient; Joan R. Chodorkoff, Ph.D., Bernard Chodorkoff, M.D., Ph.D.**

217 **Development of a Program of Laryngoscopy, Therapeutic Bronchoscopy and Endobronchial Blocking Techniques: A Progress Report; Martin L. Norton, M.D., F.A.C.C.P.**

221 **Diabetes and Pregnancy — Preliminary Report; Nancy T. Caputo, M.D., Agna N. Pineda, M.D.**

223 **The Electrophoresis of Lipoproteins; John G. Batsakis, M.D., Martha M. Thiessen, B.S. (ASCP)**

SPECIAL ARTICLES

220 **Accidental Poisoning: Where Do We Go From Here?; George M. Lowrey, M.D.**

226 **New HEW Study Discredits Chiropractors; M. A. Riley**

231 **Michigan's New Governor; Judith Marr**

234 **Participation in MVF; John M. Wellman, M.D.**

238 **This is WA-SAMA; Mrs. C. E. Crook**

266 **New Malpractice Insurance Rates; Richard Campau**

268 **Questions and Answers about MARMP; Albert E. Heustis, M.D., M.P.H.**

SINGLE MEDICAL PRACTICE ACT: Full Text pages 240 to 244, Inclusive

PRESIDENT'S PAGE

195 **No Such Thing As A 'Wise Quack'; James J. Lightbody, M.D.**

PHOTO SECTION, Pages 253 to 260 Inclusive

OTHER FEATURES

191 **Breaking News**

200 **Our State Society**

201 **Council Minutes**

212 **Monthly Surveillance Report**

246 **Socio-Economic**

276 **Ancillary**

285 **New Members**

288 **Editorial Views**

291 **MSMS Members in the News**

292 **County Societies**

296 **In Memoriam**

300 **Notes and Quotes**

The cover calls attention to the 1969 MSMS Conference on the Medical Aspects of High School Athletics May 8 at MSU. The art is from the AMA "Today's Health Guide."

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at Lansing, Michigan. Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351.

© 1969 Michigan State Medical Society.

In case you missed it last time we repeat the invitation

John C. McCabe

Blue Shield of MICHIGAN

MICHIGAN MEDICAL SERVICE • 441 E. JEFFERSON AVE. • DETROIT, MICHIGAN 48226

Dear Doctor:

Like all busy men, you probably find it difficult to keep up with everything that's going on in today's changing world, perhaps even in your own specialty.

At Blue Shield we have several ways in which we try to keep you informed, but we know that despite our best effort, you may have questions about what we do and how or why we do it.

Maybe you find a certain billing procedure puzzling, or you have a question concerning our new Michigan Variable Fee plan, MVF. Maybe you'd simply like to invite our comment on a Blue Shield philosophy of operation.

So please drop us a line if you have a question. We'll guarantee a prompt reply, and we'll do our best to help you.

After all, that's our business.

John M. Wellman

John M. Wellman, M.D., Chairman of the Board

John C. McCabe

John C. McCabe, President



MICHIGAN STATE MEDICAL SOCIETY

120 West Saginaw (P.O. Box 152)
East Lansing, Mich. 48823
Area Code 517, 337-1351

1010 Antietam Road
Detroit 48207
Area Code 313, 965-0541

PRESIDENT..... James J. Lightbody, M.D.....Detroit
PRESIDENT-ELECT.. Robert J. Mason, M.D.....Birmingham
SECRETARY..... Kenneth H. Johnson, M.D.....Lansing
TREASURER..... John R. Ylvisaker, M.D.....Pontiac
SPEAKER..... James B. Blodgett, M.D.....Detroit
VICE-SPEAKER..... Vernon V. Bass, M.D.....Saginaw
PAST PRESIDENT.... Bradley M. Harris, M.D.....Ypsilanti

COUNCIL CHR..... Ross V. Taylor, M.D.....Jackson
VICE-CHAIRMAN.... Ralph R. Cooper, M.D.....Detroit

COUNCILORS:

Sidney Adler, M.D.....1st.....Detroit
Ralph R. Cooper, M.D.....1st.....Detroit
Don W. McLean, M.D.....1st.....Detroit
Milton R. Weed, M.D.....1st.....Grosse Pointe Park
Robert K. Whiteley, M.D.....1st.....Detroit
Ross V. Taylor, M.D.....2nd.....Jackson
Harvey C. Hansen, M.D.....3rd.....Battle Creek
Don Marshall, M.D.....4th.....Kalamazoo
John R. Pedden, M.D.....5th.....Grand Rapids
Harold H. Hiscock, M.D.....6th.....Flint
John J. Coury, M.D.....7th.....Port Huron
A. Carl Stander, M.D.....8th.....Saginaw
Robert V. Daugharty, M.D.....9th.....Cadillac
Edward H. Rodda, M.D.....10th.....Bay City
Brooker L. Masters, M.D. .....11th.....Fremont
Wm. A. LeMire, M.D.....12th.....Escanaba
J. Robert Franck, Jr., M.D.....13th.....Wakefield
Harold F. Falls, M.D.....14th.....Ann Arbor
Sydney Scher, M.D.....15th.....Mt. Clemens

EXECUTIVE DIRECTOR...Hugh W. Brenneman East Lansing
ASSOCIATE EX. DIR..... Warren F. Tryloff....East Lansing
GENERAL COUNSEL.....Lester P. Dodd.....Detroit
LEGAL COUNSEL..... A. Stewart Kerr.....Detroit
ECON. CONSULTANT.....Clyde T. Hardwick.....Detroit
HISTORIAN..... Wm. J. Stapleton, Jr., M.D. Detroit
ASS'T HISTORIAN..... Wm. M. LeFevre, M.D. Muskegon

SCIENTIFIC EDITOR
John W. Moses, M.D., Detroit

EXECUTIVE EDITOR
Herbert A. Auer

MANAGING EDITOR
Judith Marr

ASSOCIATE SCIENTIFIC EDITORS
Frederick J. Cady, Jr., M.D., Surgery
Saginaw
Robert M. Daugherty, M.D., Basic Science
East Lansing
Harold E. De Pree, M.D., Medicine
Kalamazoo
Dean C. Elliott, M.D., Otolaryngology
Petoskey
Tommy N. Evans, M.D., Obst.-Gyn.
Detroit
Dorin L. Hinerman, M.D., Pathology
Ann Arbor
Samuel D. Jacobson, M.D., Medicine
Detroit
Benjamin Jeffries, M.D., Psychiatry
Detroit
Raymond S. Kurtzman, M.D., Radiology
Detroit
A. Martin Lerner, M.D., Medicine
Detroit
George H. Lowrey, M.D., Pediatrics
Ann Arbor
Carl A. Moyer, M.D., Surgery
East Lansing
Charles E. Parkinson, M.D., Radiology
Battle Creek
John C. Pierce, M.D., Medicine
Grand Rapids
Frank H. Power, M.D., Surgery
Traverse City
J. G. Turcotte, M.D., Surgery
Ann Arbor
Alexander J. Walt, M.D., Surgery
Detroit
Park W. Willis, III, M.D., Medicine
Ann Arbor
Richard E. Wunsch, M.D., Medicine
Traverse City

Publication Committee

Brooker L. Masters, M.D.
Harvey C. Hansen, M.D.
William A. LeMire, M.D.
Don Marshall, M.D.
Don W. McLean, M.D.
Edward H. Rodda, M.D.
Milton R. Weed, M.D.

1969 Judicial Commission Re-Elects Doctor Sweeny

Donald L. Sweeny, Jr., M.D., Detroit, was re-elected chairman of the MSMS Judicial Commission at the first meeting of 1969 at MSMS headquarters.

Harold A. Furlong, M.D., Pontiac, was re-elected vice chairman.

The MSMS Constitution and Bylaws provide for the election of a Judicial Commission, which has general jurisdiction in matters relating to professional ethics, grievances, mediation, discipline and professional conduct of members.

NEW COMMITTEE TO BRING MSMS, MHA CLOSER TOGETHER

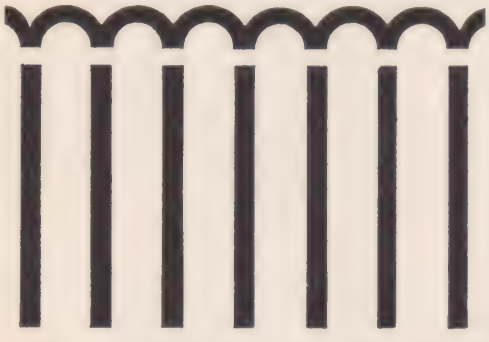
Cooperation between MSMS and the Michigan Hospital Association is being furthered through the newly-constituted Hospital Relations Committee, which met for the first time Feb. 26.

The committee is charged with studying ways to implement resolutions passed by the 1968 House of Delegates meetings of both MSMS and the MHA. The resolutions encourage MSMS and MHA to work out mutual problems among themselves rather than let them go to the hands of public office-holders.

The wording of the MHA House of Delegates resolution was almost identical to the MSMS resolution, which said, "Resolved, that when there are differences between the two societies about medical care or its administration, we make vigorous efforts to resolve these problems between ourselves, to preclude the arbitration of medical debates by the legislature."

Medical Exhibitors Elect Tryloff

Warren Tryloff, associate executive director of MSMS, is the new president-elect of the Professional Convention Management Association, a joint society of medical exhibitor representatives of pharmaceutical companies and medical societies. Mr. Tryloff had been serving as treasurer.



OUR STATE SOCIETY

Michigan Mediscene

March 12-13 — Sparrow Hospital Hypertension Clinic, MSU Regional Medical Programs, Hypertension Symposium, Kellogg Center, East Lansing

March 20 — American Cancer Society, Michigan Division, Second Annual Cancer Conference for Nurses, Rackham Building, University of Michigan

March 25-26 — Michigan Association of Sanitarians, Annual Educational Conference, Gull Lake Conference Center, Gull Lake

March 27 — Michigan Tuberculosis and Respiratory Disease Association, Tri-County Office, Respiratory Disease Seminar for Physicians, Delta College, University Center

April 10 — Michigan Thoracic Society, University of Michigan

April 15 — Michigan League for Nursing, Council on Practical Nursing, MEA Conference Center, St. Mary's Lake, Battle Creek

April 16 — Michigan League for Nursing, Annual Conference, MEA Conference Center, St. Mary's Lake, Battle Creek

April 17 — Michigan Tuberculosis and Respiratory Disease Association, Ingham County Tuberculosis and Respiratory Disease Association, Respiratory Disease Seminar for Nurses, Union Ballroom, MSU

April 22-23 — Michigan League for Nursing Institute, "Developing the Climate for Continuing Education," Holiday Inn, Marquette

April 30 — Michigan Tuberculosis and Respiratory Disease Association, Respiratory Disease Seminar for Physicians, Statler-Hilton Inn, Benton Harbor

May 7-9 — Michigan Public Health Association Annual Meeting, Pick-Durant Hotel, Flint

May 15-16 — Michigan Dietetic Association Spring Meeting, Hidden Valley

May 15-18 — National Student Nurses Association, Annual Convention, Cobo Hall, Detroit

May 19-23 — National League for Nursing, Biennial Convention, Cobo Hall, Detroit

June 17-19 — Michigan Department of Public Health, Northern Regional Nurses' Conference, Birch Lodge, Higgins Lake

FIVE TO REPRESENT MSMS ON MAP CONGRESSIONAL TRIP

Five top office-holders and staff chiefs will represent MSMS on the annual Michigan Association of the Professions Congressional Trip to be held in conjunction with the 57th annual meeting of the Chamber of Commerce of the United States April 27-29 in Washington, D.C.

The five are James J. Lightbody, M.D., MSMS president; Robert J. Mason, M.D., president-elect; Ross V. Taylor, M.D., chairman of The Council; Hugh W. Brenneman, executive director, and Ralph Wills, director of community relations.

Extract of January Council Meeting

The following are highlights of the January 29, 1969, meeting of The MSMS Council. Submitted by Ross V. Taylor, M.D., chairman.

The Council reviewed correspondence regarding the flu vaccine controversy between Parke-Davis, Bell Telephone, MSMS and the AMA re distribution of the vaccine, which in the MSMS view, had been mishandled.

Michigan Medical Service reported to The Council on the recent activities of the Social Security Administration in the matter of medical costs, a progress report on regional medical advisory committees, participation status report, and enrollment activities under the MVF program. Members of The Council reported complaints from their districts about Blue Shield letters sent to patients concerning payments.

Council meetings for November and December were rescheduled one week in advance of the current schedule. New dates, November 5 and December 10.

Preliminary plans were reviewed by The Council regarding the Second Annual Health Planning Conference sponsored by MSMS which will be held this year on April 16-17 at Western Michigan University, Kalamazoo.

Chairman Taylor instructed the standing committees of The Council to conduct an evaluation of all MSMS committee activities.

Chairman Taylor announced that at the Joint Conference on Medical Conventions in Atlanta, Georgia in January, Mr. Tryloff, MSMS Associate Executive Director, had been named President-Elect of the Professional Convention Management Association.

A LETTER from the Wayne County Medical Society requesting that immediate action be taken to provide that all doctors be exempted from jury duty was referred to the MSMS Legal Affairs Committee for consideration and action.

The Council approved the introduction of the proposed single medical practice act which had been reviewed by the House of Delegates and modified according to recommendations from component societies.

The Council heard a presentation and discussed with Dean William Hubbard, M.D., at the University of Michigan Medical School, the changes in the current medical school structure and plans for increasing its size. He reported that U of M has submitted a proposal to the Legislature to increase the size of the entering class from 205 to 225 as soon as appropriations are available. A long-term plan would be to move up to 300 students.

The Council appointed representatives to attend the AMA Joint Meeting on Revised Standards for Hospital Accreditation, First National Conference on Abortion Laws, the American Medical Association and American Bar Association National Medical-Legal Symposium, and the AMA Second National Conference on Nursing.

The Council also authorized MSMS officers to attend a National Chamber of Commerce meeting in Washington.

President Lightbody announced the appointment of Dr. Floyd B. Levagood, Detroit, to the MSMS Judicial Commission to fill the vacancy left by Doctor Bailey's resignation.

PRESIDENT LIGHTBODY reported a telegram sent by MSMS on December 21 to the then Secretary of Health, Education and Welfare, Mr. Wilbur Cohen, concerning the premium rate for Medicare supplemental insurance plan, objecting to some of the language used by Mr. Cohen in announcing his decision re this rate.

The Council authorized a letter of thanks to Governor Milliken for his support of the MSU Medical School expansion as evidenced in the new Michigan budget. The Council received notification of a forthcoming health examination survey in Macomb, Oakland and Wayne counties and another in Lapeer and St. Clair counties and instructed that the component societies involved be informed of the coming study at the earliest possible date.

President-Elect Mason gave a progress report on the AMA Education Research Foundation, which is now aiding 19,300 medical students, hospital interns and residents under the loan guarantee plan which has guaranteed $45,400,000 on loan from local banks throughout the nation.

Speaker Blodgett reported progress in selecting House of Delegates committees for 1969.

Regarding current letters being sent to patients by Blue Shield, The Council approved the following County Societies Recommendation:

"That The Council Chairman be requested to direct a strong letter to the Blue Shield Board Chairman stating that these letters imply that physicians' fees are unreasonable, tend to intimidate physicians, tend to set fees for doctors and tend to come between physicians and their patients and

(Continued on Page 205)


It takes more than a pill
to lose weight

That's why Abbott's got what it takes–
a pill and a program for each patient

THE PRODUCT–5 Different Strengths

For smooth appetite control plus mood elevation

Desoxyn® Gradumet®

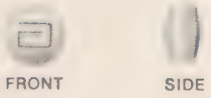
Methamphetamine Hydrochloride in Long-Release Dose Form



For patients who can't take plain amphetamine

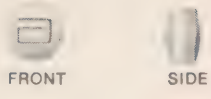
Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride, 60 mg. Sodium Pentobarbital



Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride, 90 mg. Sodium Pentobarbital



THE PROGRAM–3 Patient Booklets



Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably —and permanently. Food exchanges and a comprehensive list of foods, showing their calories, are also included.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

Compact new booklet features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

902110

ABBOTT

Please see Brief Summary on next page.

Ask Your Abbott Man For Patient Supplies.

BRIEF SUMMARY

Desoxyn® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

Desbutal® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

Desbutal 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates, or in those with history of manifest or latent porphyria.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Because of its sodium pentobarbital content, use Desbutal with caution in patients receiving coumarin anticoagulants. Pentobarbital may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

902110

ABBOTT



MSMS members may obtain copies of the AMA "Horizons Unlimited" career handbook with an eight-page Michigan insert by writing to MSMS, P.O. Box 152, East Lansing 48823.

Achromycin V
250 mg. capsules

ACHROMYCIN® V
TETRACYCLINE HCl

Lederle

4810-3

that it is recommended that Blue Shield merely inform their subscribers that they have made a payment to the physician (or patient) which fulfills their contractual relationship."

Regarding the proposed MSMS-sponsored program of professional liability insurance from the Employment Insurance Company, The Council authorized that a special insurance consultant be retained to review the entire matter and make a report to The Council and the Committee on Professional Insurance Plans, giving his conclusions and recommendations.

At this annual meeting of The Council the following elections and appointments were made: Secretary, Kenneth H. Johnson, M.D.; Treasurer, John A. Ylvisaker, M.D.; Assistant Secretary, Brooker L. Masters, M.D.; Assistant Treasurer, C. Allen Payne, M.D.; Scientific Editor, John W. Moses, M.D.; Executive Director, Hugh W. Brenneman; Associate Executive Director, Warren F. Tryloff.

FOLLOWING THE LEAD of the American Medical Association House of Delegates action at the Miami meeting in November, 1968, The Council recommended to the Committee on Constitution and Bylaws of the House of Delegates that it consider amending the Constitution to permit acceptance of qualified doctors of osteopathy as members of the Michigan State Medical Society and component medical societies throughout regular procedures.

Chairman Taylor reported to The Council those resolutions referred by the House of Delegates to The Council and his recommendation for implementation.

Doctor Blackhurst Receives First Detroit Society Award

R. T. Blackhurst, M.D., Midland, chairman of the MSMS Eye Care Committee, is the recipient of the first Maude Helen Cluff Award of the Detroit Society for Prevention of Blindness.

Doctor Blackhurst was surprised with the presentation at the 22nd annual meeting of the Society in Detroit Jan. 30. He was cited particularly for his contributions to the development of preschool visual screening programs which have been implemented nationally and will become law for Michigan children entering kindergarten in 1970.

The award, according to William F. Harfen, executive director of the Detroit Society, will be given annually to a physician, other professional or a volunteer who has rendered outstanding service in the prevention of blindness in Michigan.

Please Note Correction To Action by Delegates To '68 Resolution #34:

MSMS members — and especially members of the House of Delegates — are urged to clip the following correction to the Proceedings of the 1968 House of Delegates and to insert it on page 52 of the Proceedings.

The printed Proceedings, mailed to every member of MSMS as one of the three December issues of *Michigan Medicine,* contained an error in reporting the House action on Resolution 34. The printed Proceedings reported that the House adopted the resolution as presented — but the House approved the resolution only after makeing three changes in the "Resolved" portions. The Resolution as presented originally is printed below, followed by the action of the delegates:

RESOLUTION 34

Use of Computer Techniques by the Board of Registration in Medicine

Introduced by Alexander Blain, III, MD

Whereas, some 600 doctors of medicine are examined each year for a license to practice in Michigan, and

Whereas, the preparation of the examinations requires about 300 hours work by each member of the Board, and

Whereas, the number of eligible applicants will increase by about 25% with the expansion of the Wayne State University School of Medicine and the operation of the Michigan State University School of Human Medicine as a four year school, and

Whereas, there is an increasing demand for the examination of individuals and small groups at various times between regular examinations given in January and June, and

Whereas, this increasing work load requires the use of improved and advanced techniques to render acceptable service, therefore be it

RESOLVED: That the MSMS does hereby recommend that the Board of Registration in Medicine explore all possibilities and adopt such modern and advanced techniques as, in its opinion, may best serve to expedite its lawful function of examination, licensure and regulation of the practice of medicine in Michigan, and be it further

RESOLVED: That an adequate fee, commensurate with the cost, be charged for such service.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the resolution.

THE HOUSE approved the resolution after amending it as follows:

In the first Resolved, strike the words "regulation of the" and substitute "enforcement of the lawful."

Add, at the end of the second Resolved, the words "and proper confidentiality of such records be established and enforced."

Four Doctors Join Education Committee

Appointments to the Education Liaison Committee for 1969 include four new members.

Milton R. Weed, M.D., Grosse Pointe Park, was reappointed committee chairman by Council Chairman Ross V. Taylor, M.D., Jackson. Committee members D. A. Haddock, Jr., M.D., Kalamazoo, and D. Bonta Hiscoe, M.D., Lansing, were also reappointed.

The new members are K. L. Krabbenhoft, M.D., Detroit; Peter V. Kane, M.D., Mt. Clemens; Edward F. Kickham, M.D., Saginaw, and William G. Birch, M.D., Kalamazoo.

Advisors to the committee include the deans of Michigan's three medical schools, Andrew D. Hunt, Jr., M.D., Michigan State University; Ernest Gardner, M.D., Wayne State University, and William N. Hubbard, Jr., M.D., University of Michigan. Luther R. Leader, M.D., Royal Oak, secretary of the State Board of Registration in Medicine, is also an advisor.

The purpose of the Education Liaison Committee is to advise The Council on all matters pertaining to undergraduate medical education, to set up and coordinate courses dealing with medical economics and medical ethics in the medical schools and to advise The Council on licensure with the Michigan State Board of Registration in Medicine.

Its major activities, continued from last year, include the further study of the feasibility of training "physician's assistants," further efforts to encourage medical students, residents and interns to stay and practice in Michigan and other liaison activities with the medical schools.

Michigan Doctors Urged To Refer Deaf-Blind Children to School

Michigan doctors are again being urged to inform the Michigan School for the Blind of any deaf-blind children in their knowledge.

A survey-questionnaire for referring deaf-blind children to the school and the Maternal Child Health Bureau of the Michigan Department of Health was sent in July to all MSMS members.

A total of 580 replies were received, with 30 doctors reporting children with the double handicap. The doctors were personally contacted and home visitations were then made to the children.

The School for the Blind and State Health Department personnel hope that more doctors will fill out the questionnaire, sent in the form of a post card, and return it, so that children both deaf and blind may find treatment through the school's new Project for Early Childhood Blind-Deaf Children.

Doctors who have misplaced the postcard may refer to the reprinted form below, for a list of the questions asked. The cards or similar information are to be mailed to M. S. Polzien, Principal, Michigan School for the Blind, 715 W. Willow, Lansing, 48906.

The MSMS Eye Care Committee has charge of the project to contact doctors which was initiated because the Michigan School for the Blind is expanding its facilities and special teachers are being trained at Michigan State University to teach these deprived children. There are currently only seven places in the nation where deaf-blind children may be educated.

BLIND-DEAF QUESTIONNAIRE

The purpose of this questionnaire is to bring educational aid to child and family. (This includes children from 0 - 20 years.)

Do you have under your care or do you know of a blind-deaf child?

Yes_____ No_____

If Yes: How Many?_____ Approximate Age (s)_____

Comments _____

_____

_____

_____

Dr. _____

Address _____

_____

Desk Reference Cards for Stroke Supply Latest Treatment Information

"There have been remarkable but little publicized advances in the understanding of cerebrovascular disease and the treatment of the stroke syndrome in the last decade. The era of therapeutic nihilism has passed in the treatment of either the acute stroke or chronic cerebral arteriosclerosis with the availability of active therapy for prevention of stroke, for treatment of the acute episode, and the rehabilitation of the stroke patient.

"In the majority of cases, cerebrovascular disease develops after many years of advancing cerebral arteriosclerosis. The major predisposing factors are chronic hypertension, diabetes mellitus and disturbances of lipid metabolism, often expressed by elevated serum cholesterol levels. Each of these three major factors can be treated, and control may delay the development of arteriosclerosis. The reported decrease in the incidence of intracerebral hemorrhage in the last decade may reflect the wider use of antihypertensive drugs and, presumably, improved control of chronic hypertension.

"Cerebral arteriosclerosis develops insidiously over a period of many years prior to the development of symptoms. Unfortunately, some patients present with an acute stroke as the initial manifestation of the disease, but at least 50% of patients have one or more episodes of transient ischemia before the major attack, with full recovery. These patients should have a full evaluation, and the Stroke Cards published in this issue of the Journal, should be valuable in giving guidance in this highly technical field."

Michael C. Kozonis, M.D.
President
Michigan Heart Association

John Gilroy, M.D.
Chairman
Michigan Heart Association
Stroke Committee

TEAR OUT AND SAVE MHA CARDS

Michigan physicians will find in this issue of *Michigan Medicine* a set of **Desk Reference Cards for Stroke**, published and revised by the Stroke Committee of the Michigan Heart Association.

This first set, beginning with differential diagnosis, will supply in a condensed and easily available form, the latest information on the active treatment of the many medical problems of acute cerebral vascular disease. The 4 x 6 inch cards, printed on both sides, are perforated for easy removal, and punched for fastening with a ring or metal pin.

In 1967, in Michigan, vascular lesions of the nervous system killed 7,846, of whom 1,508 were under 65. Hospital studies indicate that one-third of all stroke admissions die within 48 hours.

A second set of cards, dealing with the rehabilitation of stroke patients, will be offered in a later issue of *Michigan Medicine*. Both sets, along with a set dealing with Rheumatic Fever and Heart Disease, are available without charge on request to the Michigan Heart Association, a Michigan United Fund Agency.

In the following passage, Dr. Michael C. Kozonis, President of the Association, and Dr. John Gilroy, Chairman of its Stroke Committee, express the gratitude of the Heart Association to the Michigan State Medical Society for affording this opportunity to further the work of the Stroke Committee.

VALENTINE'S DAY FORUM FEATURES DOCTOR BING

Warnings about heart attack and stroke were brought to Southern Oakland County by Richard J. Bing, M.D., Detroit, at the Valentine's Day Heart Forum Feb. 14 at the George Washington Carver Elementary School in Royal Oak Township.

Doctor Bing, chief of medicine at the WSU School of Medicine, described heart attack and high blood pressure. Also featured at the forum, sponsored by the Michigan Heart Association, was Rupert L. Edwards, M.D., who did a heart examination of a volunteer on stage.

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (*see* Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

900134

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

ABSTRACT: The occurrence of myocardial infarction during the hyperthyroid state has been reported to be very uncommon. A review of the available literature has revealed only fourteen documented, unequivocal instances of this association to date.[1,2,3] The purpose of this presentation is to add one case to the literature on this subject.

Myocardial Infarction During Hyperthyroidism

By ROBERT C. DOUGLASS, M.D., FARMINGTON
MYER TEITELBAUM, M.D., DETROIT
GERALD J. ABEN, M.D., SOUTHFIELD

The rarity of acute myocardial infarction in hyperthyroidism prompted a study of all hyperthyroid patients admitted during the years 1960 through 1966 in ten large Detroit metropolitan area hospitals.[4]

There were 1,568 cases of hyperthyroidism in this group. In only one case was acute myocardial infarction shown to be present during the hyperthyroid state. It occurred in a patient at Providence Hospital. In nine other cases both diseases were possibly associated. Four of these were euthyroid when myocardial infarction was suspected; one patient was a diabetic and three showed only questionable electrocardiographic changes. One other patient, clearly hyperthyroid, had electrocardiographic findings suspicious of lateral extension of an old posterior myocardial infarction.

Materials and Results

A survey of all admissions to Providence Hospital of hyperthyroidism, from 1962 to 1966, was included in the ten-hospital group cited. There were 95 verified cases during this interval, 80 female and 15 male patients in this group. Surgical thyroidectomy was performed on 47 and I-131 therapy administered to 18. The remaining 30 were treated with antithyroid drugs.

In this Providence Hospital group of 95 there were four patients with hypertensive heart disease, one with congenital heart disease and one with heart disease due to calcific aortic stenosis. Also, there were three patients with congestive heart failure of undetermined origin, seven with roentgenologic evidence of cardiomegaly only, seven with nonspecific EKG abnormalities only, and one with arrhythmia only (supraventricular tachycardia).

Five patients in this group of 95 with hyperthyroidism had clear-cut evidence of arteriosclerotic heart disease. Two of them had angina pectoris concomitant with hyperthyroidism; both also had diabetes mellitus. In addition, two patients had a history of myocardial infarction occurring apparently prior to development of hyperthyroidism; one of these was a diabetic also. One patient had an acute anteroseptal myocardial infarction while hyperthyroid, the only clear-cut instance found in the 1,568 cases of hyperthyroidism in the survey. The report of this case is herewith presented.

Case Report

A 36-year-old man was admitted to Providence Hospital in September 1967 because of unresolved pneumonitis. He had been ill for about two weeks with malaise, weakness, chills and fever, anorexia and a fifteen pound weight loss. Chest X-ray was compatible with pneumonitis of right medial base.

Complete physical examination at time of admission was normal except for findings consistent with pneumonitis and very rapid deep tendon reflexes. Blood pressure was 136/90 mm. of Hg. There were no eye signs of thyroid disease and no goiter was palpable.

Initial laboratory studies were normal except for white blood cell count of 4,800 per cu. mm. Sputum culture grew Diplococcus pneumoniae, sensitive to penicillin, with which he was treated. An electrocardiogram just before admission was interpreted as normal.

The temperature was normal upon admission and throughout the hospital course. Pulse rate varied in range of 90-112 per minute. Improvement in pneumonitis occurred, with evidence of

Doctor Douglass is a clinical assistant professor of medicine, Wayne State University School of Medicine, and attending physician at Providence Hospital in Southfield; Doctor Teitelbaum is a clinical assistant professor of medicine at Wayne State University School of Medicine; and Doctor Aben is attending physician, Providence Hospital.

clearing on chest X-ray on tenth day of hospitalization. However, on the fifth hospital day he had complained of retrosternal discomfort, aggravated by swallowing. An electrocardiogram was done on the thirteenth day of hospitalization and interpreted as showing acute anteroseptal myocardial infarction. Serum enzymes were elevated: SGOT 104 units and LDH 220 units, the latter rising to 650 units. A PBI, drawn on the sixth day of hospitalization, was 10.8 mcg. per 100 ml.

Chest discomfort slowly improved but nausea and vomiting ensued and weight loss continued, amounting to about one pound per day. Repeated physical examination disclosed no change except for evidence of weight loss. BMR was plus 42%, serum cholesterol 125 mg. per 100 ml. and I-131 uptake 75% in six hours and 66% in twenty-four hours.

Antithyroid drug treatment was initiated and subsequently the nausea and vomiting subsided. The patient began to gain weight. Electrocardiogram on the twenty-sixth day showed acute anteroseptal infarction, appearing unchanged and stable.

He then became asymptomatic, gained weight, and was discharged home, improved, on the fifty-third day. Subsequent readmission occurred approximately five months later, at which time he appeared clinically euthyroid. A 35 pound weight gain had occurred. Two days after admission an uneventful subtotal thyroidectomy was performed. The pathology report of the surgical specimen was "diffuse hyperplasia of thyroid gland."

Discussion

An extensive literature has accumulated on the relationship between atherosclerotic cardiovascular disease and disordered thyroid function. Attention will be limited here to atherosclerotic heart disease and coexistent hyperthyroidism, in which the clinical situations of both angina pectoris and myocardial infarction are to be considered.

Typical angina pectoris may infrequently occur during the hyperthyroid state. Levine and Somerville[1] have suggested that the increased metabolic rate of the heart in hyperthyroidism may induce angina if some degree of coronary atherosclerosis exists. This occurs when the blood supply of the myocardium is unable to meet the increased metabolic demands made upon it. The coronary blood flow may be adequate in the euthyroid state, however. Disappearance of angina pectoris following subtotal thyroidectomy for hyperthyroidism has been reported by Lev and Hamburger.[5]

The rarity of myocardial infarction during the course of active hyperthyroidism has been observed by others. Littman[2] described three cases of this association in 1957, in one of which death occurred. Autopsy in the latter case disclosed thrombotic occlusion of an atherosclerotic coronary artery. An interesting feature described in all three cases was the relatively mild nature of the attack of chest pain. In 1960 Burstein[3] reviewed the available literature and found a total of seven clear-cut examples of the association to that date. He reported seven additional cases (three with normal PBI values) from a total of 384 hyperthyroid patients. Suspicious findings of myocardial infarction were also found in an additional eight of the 384. These cases were reported from Finland, where the incidence of elevated serum cholesterol levels and coronary artery disease is exceptionally high. There is also a moderate degree of endemic, iodine-deficiency goiter known in this country. Burstein concluded that the incidence of myocardial infarction during hyperthyroidism was the same as in the general Finnish population. He also noted the rather mild nature of clinical symptoms of chest pain in the affected hyperthyroid cases.

Three reports have appeared in the Scandinavian literature of myocardial infarction occurring in conjunction with I-131 treatment of hyperthyroidism.[3,6,7]

The apparent rarity of the association of myocardial infarction during hyperthyroidism in the U.S.A. led to the previously — described survey of cases in ten large metropolitan hospitals in Detroit, Michigan.[4] The findings of only one clear-cut example among 1,568 cases of hyperthyroidism clearly indicates the rarity of this association in this area. The symptoms of chest pain and clinical course also revealed the relatively mild nature of the infarction. The rarity of association suggests a possible protective effect of pre-existing hyperthyroidism against myocardial infarction.

It is relevant here to consider factors that may be operative in effecting a selective protective process against coronary atherogenesis in hyperthyroidism. A cholesterol mechanism may be involved, perhaps the converse of that of hypothyroidism. The increase in coronary arterial blood flow or increase in myocardial metabolism in hyperthyroidism may play a role. The hyperthyroid state may possibly modify the effect of catecholamines on the arterial wall. At present, the relative importance of these, or other factors, is not clearly defined.

Summary

The occurrence of myocardial infarction was surveyed in all cases of hyperthyroidism admitted to 10 Detroit metropolitan area hospitals during the years 1960 through 1966.

One case was found in which the two diseases occurred concomitantly, and is described. This was the only clear-cut example among 1,568 patients with hyperthyroidism in the total series in-

cluding the 95 in the Providence Hospital group. The clinical features of myocardial infarction were relatively mild in this patient, as previously described by others. This represents the fifteenth such case reported in the medical literature, emphasizing the rarity of the association.

References

1. Somerville, W.; and Levine, S. A.: *Brit. Heart J.* 12: 245, 1950.
2. Littman, Donald S.; Jeffers, W. A. and Rose, E.: The Infrequency of Myocardial Infarction in Patients with Thyrotoxicosis, *Am. J. Med. Sc.,* 233: 10, 1957.
3. Burstein, Josef; Lamberg, B. A. and Eramaa, E.: Myocardial Infarction in Thyrotoxicosis, *Acta Med. Scandinavica,* 166: 379, 1960.
4. Teitelbaum, Myer; Taylor, N. M., et al: Hyperthyroidism and Myocardial Infarction, Incidence, read before the Sixth Annual Thyroid Workshop, Wayne State University School of Medicine, Detroit, Michigan, Jan. 25, 1967.
5. Lev, M. W. and Hamburger, W. W.: *Am. Heart J.,* 8: 112, 1932.
6. Ohela, K. and Rytilä, A.: *Duodecim (Finn.),* 72: 113, 1956.
7. Christensen, B. C., et al: *Acta Med. Scandinavica,* 154: 275, 1956.

Scientific Articles Printed to Date

Each month *Michigan Medicine* prints selected outstanding scientific articles. To date the following papers (with month, page number and author following) have been published:

JANUARY

Page 31, "Lower Lung Field Tuberculosis," by Ma. Zenaida Fernandez, M.D., Zamboanga City, The Philippines, and Edward G. Nedwicki, M.D., Allen Park.

Page 36, "Use of Cholesterol Kits," by Kenneth R. Wilcox, M.D., (Reprint from *New England Journal of Medicine,* Vol. 279, No. 18).

Page 37, "Mammography and Xeroradiography," by John N. Wolfe, M.D., Detroit.

Page 39, "Early Management of Facial Nerve Trauma," by Roger Boles, M.D., Ann Arbor.

Page 45, "Treatment of Hypercalcemia," by Joseph J. Weiss, M.D., and Jose Yanez, M.D., both of Eloise.

Page 49, "More Drugs Mean More Problems in Managing Diabetes Mellitus," by John B. Bryan, M.D., F.A.C.P., Royal Oak.

FEBRUARY

Page 119, "The Future of Private Practice: Salvation at the Grass Roots," by Lewis A. Miller, editor, *Patient Care,* Stamford, Conn.

Page 131, "Mouse Toxicity of Triple Vaccine (DTP) Mixed with Poliomyelitis Vaccine," by R. Y. Gottshall, G. R. Anderson, E. A. Nelson and K. R. Wilcox, M.D., all of Lansing.

Page 135, "Massive Intra-articular Injection of Methylprednisolone Without Harmful Side Effect," J. C. Breneman, M.D., Galesburg.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT
CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
FOR THE FOUR-WEEK PERIOD ENDING JANUARY 31, 1969

	1969 This 4-Week Period	1968 Same 4-Week Period	1969 Total To Above Date	1968 Total Same Date
Measles	12	31	12	31
Whooping Cough	7	43	7	43
Diphtheria	0	0	0	0
Mumps	363	1,854	363	1,854
Scarlet Fever & Strep Sore Throat	918	1,072	918	1,072
Tetanus	0	0	0	0
Poliomyelitis (Paralytic)	0	0	0	0
Hepatitis	213	148	213	148
Salmonellosis (Other than S. typhi)	37	40	37	40
Typhoid Fever (S. typhi)	0	0	0	0
Shigellosis	34	14	34	14
Aseptic Meningitis	7	5	7	5
Encephalitis	10	7	10	7
Meningococcic Meningitis	22	14	22	14
H. Influenzal Meningitis	2	3	2	3

	1969 This 5-Week Period	1968 Same 5-Week Period	1969 Total to 1/31/69	1968 Total Same Date
Tuberculosis	217	302	210	297
Syphilis	437	583	437	583
Gonorrhea	1,609	1,783	1,609	1,783

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

Trichophyton Violaceum

BY JAMES D. STROUD, M.D.
JULES ALTMAN, M.D.
COLEMAN MOPPER, M.D.
ALL OF DETROIT

Introduction

Trichophyton violaceum is a cosmopolitan, anthropophilic fungus which is the dominant etiological agent of tinea capitis in Brazil, Italy, Portugal, U.S.S.R., Spain, Yugoslavia, Algeria, Egypt, Tripoli, Tunisia, China, India and Israel.[1] It is relatively uncommon in the western hemisphere except in Brazil where it is endemic.[2] T. violaceum causes infections of the scalp, beard, glabrous skin and nails. In the United States, it is found chiefly in immigrants or their siblings, but sporadic cases have been noted in native stock. Most of the initial infections occur in children, but the disease may persist into adult life.[3] Recently we have seen two cases of tinea corporis due to T. violaceum in Detroit, Michigan.

Case Report

Case No. 1: M. C. is an 18-year-old Caucasian girl of Italian descent who was seen January 22, 1968 with a two month history of a red, scaling plaque of the right side of the neck. Past medical history is non-contributory. She has lived in Detroit for three years and no members of her family have been outside the city during this time. On physical examination she had a 3 cm. annular, red, scaling plaque of the right side of her neck. The nails and hair were not involved. Potassium hydroxide preparations were positive for hyphae, and sabouraud's culture media grew out a typical culture of T. violaceum. She was treated with 2% salicyclic acid, 2% sulfur in ½% hydrocortisone cream topically and oral griseofulvin and the lesion cleared in two weeks.

Case No. 2: S. D. is a 24-year-old Caucasian man of Italian descent who was first seen August 29, 1966 with a red, scaling eruption of his left arm and left leg of two weeks duration. He had not been out of the city for two years. On physical examination he had several scattered erythematous, excoriated plaques on his left arm and left leg. Potassium hydroxide preparations were positive for hyphae and culture grew out T. violaceum. He was treated with 2% salicyclic acid, 2% sulfur in ½% hydrocortisone cream topically and oral griseofulvin and the lesions cleared in two weeks. He was seen again on January 9, 1967 with multiple 2-3 cm. oval erythematous scaling plaques of the right side of his neck and forehead of one month duration (**Figure 1**). Potassium hydroxide preparations were positive and culture grew out typical colonies of T. violaceum. He received the same treatment as before and the skin lesions cleared in three weeks and have not recurred to this date.



Fig. 1: Erythematous scaling plaques of side of face and neck.

Comments

T. violaceum produces "black-dot" tinea capitis similar to that seen with T. tonsurans. The scalp

The authors are with the Department of Dermatology of Wayne State University School of Medicine and Detroit General Hospital. The study was supported in part by a grant from the National Institutes of Health, USPHS, and the Detroit General Hospital Research Corporation. Please address reprint requests to the Department of Dermatology, Detroit General Hospital, Detroit 48226 (Dr. Stroud).

hairs break off close to the skin and are nonfluorescent under the Woods' light.[4] According to Dostrovsky,[5] kerion develops in 1% of patients. Lesions of the glabrous skin occur in less than 1% of cases.[5] The duration of the untreated infection is usually many months or years.

T. violaceum is an endothrix organism invading the hair shaft. Direct examination of skin infected with T. violaceum shows sporulated mycelium and infected hairs shows the spores arranged in rows or beads. In culture the growth is very slow. The colony is heaped and verrucose with a smooth surface. At first the colony is cream colored, then lavender and later becoming deep purple. Old cultures may develop downy surface growth and may lose the purple pigment. Culture mount reveals thin tortuous mycelium without microconidia. Pyriform microconidia are observed on enriched media and rarely clavate macroconidia may be seen.

The most recent report of T. violaceum in Michigan was in 1962 by Bocobo, et al.[6] They reported on five siblings in a family of eight developing tinea capitis due to T. violaceum. The rare occurrence of tinea corporis due to T. violaceum in the United States prompted this report.

Summary

Two cases of tinea corporis due to trichophyton violaceum are presented. The rare occurrence of glabrous skin infections due to T. violaceum in the United States prompted this report.

Acknowledgments

Charles Jeffries, Ph.D., Department of Microbiology, Wayne State University School of Medicine, confirmed the diagnosis of Trichophyton violaceum from our cultures.

References

1. Ajello, L.; Georg, L. K.; Kaplan, W.; and Kaufman, L.: *Laboratory Manual for Medical Mycology,* U.S. Department of Health, Education and Welfare, Public Health Service, C.D.C., Atlanta, Georgia, P. D-48.

2. Rebell, G.; Taplin, D.; and Blank, H.: *Dermatophytes: Their Recognition and Identification,* Dermatology Foundation of Miami, Miami, Florida, P. 46.

3. Lewis, G. M.; Hopper, M. E.; Wilson, J. W.; and Plunkett, O. A.: *An Introduction to Medical Mycology;* 4th Edition, The Yearbook Publishers, Inc., 1958, P. 62.

4. Conant, N. F., et al: *Manual of Clinical Mycology;* W. B. Saunders Company, Philadelphia and London, 1954, P. 312.

5. Dostrovsky, A., et al: Tinea Capitis: Epidemiologic Therapeutic and Laboratory Investigation of 6,390 Cases, *J. Invest. Derm.* 24: 195, 1955.

6. Bocobo, F. C.; Miedler, L. J.; Eadie, G. A.: A Family Outbreak of Tinea Capitis Due to Trichophyton Violaceum in Michigan. Its Control with Griseofulvin; Mycopathologia et Mycologia Applicata, 16: 271-284, 1962.

Psychiatric Referral of a Pediatric Patient

By JOAN R. CHODORKOFF, Ph.D.
BERNARD CHODORKOFF, M.D., Ph.D.
BOTH OF DETROIT

When a pediatrician refers one of his patients for psychiatric evaluation or treatment questions frequently arise about the role of the parent in such a venture. They generally are clarified for the parent once treatment is underway. It may be helpful, however, in order to facilitate the referral and the start of the treatment, if the referring physician is able to communicate when necessary some aspects of information to the parent at the time he suggests the referral.

The first step is for the physician himself to have a clear understanding of the role of the parent in the treatment of the child. It is the purpose of this paper to make explicit various aspects of the role the parent inevitably will play, and describe some aspects of the relationship between the parent and the child's therapist.

Undertaking the psychiatric treatment of a child requires the involvement and encouragement of his parents. The reasons for this are: a) the young child will not, and cannot come by himself, and b) since children are realistically dependent on their families, they do react to problems in the family over which they have the least control and the least awareness. Simply stated, the least possible degree of parental involvement is the matter of bringing the child for appointments. Near the opposite end of such an "involvement continuum" are the cases in which the child's appointment is a brief ritual, making it possible for a parent to seek or pursue his or her own treatment or help for marital difficulties. We may think of the anchoring point of the "parental involvement continuum" as represented by concomitant treatment of parent and child.

Child therapists recognize the need for insight into their own inclinations to dislike, disapprove of, blame, and/or compete with parents of their patients. Such attitudes toward parents (in the referring pediatrician as well!) handicap the establishment of a relationship with the parent which would be helpful to the child.

PARENTS USUALLY BRING children to their pediatricians for psychiatric referral when they feel they can no longer cope with their children, or to put it another way, they can no longer cope with the feelings the child's behavior has stirred in themselves. As a result such parents find themselves feeling helpless in attempting to handle the child's behavior appropriately.

One thing is certain, even when the child's symptoms add up to outrageous, impulsive or destructive behavior, the parent's role is not necessarily a simple one. Logically, we would expect the parents of an unruly child to be the most anxious for help. However, some parents enjoy the child's acting out behavior without being aware of this about themselves. Furthermore, the specific form of the child's destructive or anti-social behavior may be dictated by the parent's needs, and not the child's. Here too, such parents are not aware of either their needs, or the way in which they prompt their children to gratify them in a substitute way. Should the reader not immediately think of clinical illustrations, he need only to think of those friends who visit his home with pre-school children and make no effort to limit their behavior!

MAKING SECURE THE child's treatment may actually begin with the referring pediatrician's awareness that it is not only the child who has underlying and unmet motivations. It is never possible to predict from the child's symptoms alone, the parents underlying motivation for initiating treatment. Since the child's treatment depends on the therapeutic and insightful handling of the parent's feelings, it will be the therapist's first task to determine just why the parent has come for help *now*. This is not to imply that hasty or intrusive interventions are desirable. Rather it emphasizes the efforts required of the therapist early in the planning stages of treatment. Sometimes educated guesses are made; frequently interesting surprises unfold later on.

What surprises, you may ask? We have seen children in treatment for a year before the parents felt comfortable enough to share the information that one of their relatives was psychotic, and had been hospitalized for years, or that the patient's father had been engaged in an incestuous relationship with the patient's sibling. Thorough history-taking does not protect either the pediatrician or the therapist against such surprises.

Parents readily perceive the child's coping difficulties or symptoms as a sign of their own failure. The parent responds to such perceived failure with varying degrees of anxiety, often mixed with

The authors are associated with the Department of Pediatrics, Detroit General Hospital and the Detroit Psychiatric Institute, Research, and Research Training Unit.

anger which will be expressed toward the referring pediatrician. The latter may be seen as the one responsible for the parent having to face these unpleasant feeling states. When this occurs the feeling of the parent must be skillfully dealt with by the pediatrician, otherwise the referral may fail at this stage.

The child psychiatrist and child psychologist both have a particular interest in the dynamic and defensive aspects of the parental reaction to and involvement in the child's symptoms. Very often when a child comes for diagnostic evaluation it is difficult for us to discover an objectively sound reason for the evaluation request. This may be a source of frustration to the referring physician when such difficulty is communicated back to him by the child's therapist.

What helps is to recognize that the search is for a "dynamically" sound reason, and one which may not be the apparent one as it is presented to the referring physician.

THE INTERPRETATION OF the evaluation and recommendations offered always should take into account the personal characteristics and dynamics of the parents. Communication with parents is only possible in this way. It is easy to overlook the fact that it may be as difficult to convince some parents that their child is genuinely bright, as it is to convince others that the child is not. We cannot overstress the importance of keeping uppermost in one's mind the need for respect for parent's feelings, and taking the time to understand them, when making an interpretation of an evaluation or offering specific recommendations. It goes without saying that although tact is valuable we also have a responsibility to report our impressions realistically.

Without going into clinical detail beyond the scope of this paper, here are some dimensions of the therapist-parent relationship.

1. To some extent every parent is a patient.

2. The parent faces a threat in the form of loss of self-esteem in bringing the child for treatment.

3. Often the parental guilt about the child's neurosis is in itself neurotic; that is, the guilt is displaced towards the child. The parent's behavior is *not* responsible for the child's symptoms and this should be clarified.

4. When parental guilt is realistic, the therapist must provide concrete guidance for improved handling of the child's symptoms. At some point, when it is clear, the therapist must indicate that the child's improvement is contingent upon specific changes in parental behavior.

5. The parents will be jealous of the child's attachment to the therapist.

6. Parents will wish to control the treatment — sometimes directly with regards to content, sometimes with regards to appointment times, sometimes by not following through on guidance and advice.

7. The parents will find it easy to side with the child's resistance and negative reactions to treatment.

8. Consequently, it is always necessary to offer realistic assurances that your only interest is in returning a healthier child to them, for *their* enjoyment.

9. Parents must be informed at the outset and as often as it becomes necessary during the treatment that the child's treatment may effect changes in the whole family.

10. The parent has a subtle emotional, patient-like relationship to the child's therapist which may never be interpreted as such but which the therapist uses and *must* be aware of. (Often, the therapist is the "Good Mother").

11. During the course of the treatment, some kind of therapeutic alliance should develop in the parent-therapist relationship. This may be like the observation of "ego-split" in psychoanalytic therapy.

12. Interpretation of the child's behavior may prove therapeutically useful for the parent, although this is not its primary purpose.

13. During treatment the parent sometimes identifies with the positive attitude of the therapist towards the child, which compensates for the parent's sense of guilt and failure (or wounded self-esteem in needing help for his child).

14. On the other hand, sometimes the parent identifies with the improving child who is the object of the therapist's warm concern.

IN SUMMARY, effective handling of the role of the parent-therapist relationship is essential for the child's treatment. Although the degree of intensity and frequency of contact between the child's therapist and his parents can and *must* vary, the child's therapist must be prepared for its vicissitudes and must never attempt to treat a child without either being prepared to offer this relationship to the parents or to be in regular and close contact with the person who is working with the parents. The pediatrician who refers the child can be an ally to the treatment efforts by his effective understanding of what will occur from the moment that he is called to offer a psychiatric referral. He may be the first to learn about the nature and quality of the parent's role in the child's therapy and can facilitate the future therapy work by his appropriate responses to the parent and by his communications to the therapist.

Development of a Program of Laryngoscopy Therapeutic Bronchoscopy and Endobronchial Blocking Techniques: A Progress Report

BY MARTIN L. NORTON, M.D., F.A.C.C.P.
DETROIT

This project was initiated at the Wayne State University, School of Medicine, Department of Anesthesiology, during the academic year 1967-68. The objectives were:

(A) to determine the degree of interest and related need for a course of instruction in laryngoscopy, therapeutic bronchoscopy and endobronchial blocking techniques.

(B) to develop a pertinent curriculum.

(C) to conduct a pilot program.

(D) to evaluate the program, with a view to further activity in this field.

Phase One

Phase one of our program development included many aspects not obvious at first. These included interdisciplinary relationships, funding, and proprietary organizational support. At our institution, we were fortunate in obtaining the enthusiastic support of the Professors of Surgery and Otolaryngology.

Frequent discussions were initiated with anesthesiologists and surgeons. They soon indicated a degree of interest in training anesthesiologists in these techniques beyond expectation. The need was most acute in delivery rooms (prime cause of maternal and newborn mortality being aspiration anoxia) and acute trauma centers (patients, requiring immediate surgery, who had a full stomach). Furthermore, the influx of foreign trained surgeons with the consequent increased demand for one-lung anesthesia techniques was noted. The development of the manifold field of inhalational therapy required increased use of the skills of therapeutic bronchoscopy. Investigation and evaluation of our trend towards intrapulmonary therapeutic bronchoscopy[1] appeared of significant importance. Communications expressing interests and encouragement were received from anesthesiologists, surgeons, pediatricians and obstetricians in relation to many facets of our program.

The matter of program funding was based upon the support of the Detroit General Hospital Research Corporation. This organization provided in part for an instructor refresher training course and some of the basic equipment needs. Next, we approached the various firms involved in producing related instrumentation. The continuing response of these research and development minded firms was indeed encouraging.

Phase Two

Phase two included pilot program development which involved basic science, clinical and laboratory practice aspects. A survey of related anatomy, physiology, pharmacology, and microbiology initiated the didactic program. This was supported by lectures on radiologic, pathologic, nursing and technique aspects. The laboratory sessions were divided into 4 sections — laryngoscopy, evaluative bronchoscopy, therapeutic bronchoscopy, and endobronchial blocking. Included was a session on emergency tracheostomy, with both a film[2] and practical demonstration.

All didactic sessions (**Figure 1**) were tape recorded. In addition, course evaluation forms were completed by the students. These, together with comments of the instructors form the basis of our evaluative conclusions.

The pilot program was conducted on a one-week basis with the morning sessions being primarily didactic and the afternoon sessions being limited to laboratory activity. Instructors were drawn from the related cooperating departments. We obtained instruments and equipment of many currently available types. These included fiberoptic and standard battery bronchoscopic equipment, endobronchial catheters, intubating bron-

The author is Associate Professor of Anesthesiology, School of Medicine, Wayne State University, Detroit.

FIGURE 1 PILOT PROGRAM

INTRODUCTION TO LARYNGOSCOPY, BRONCHOSCOPY AND ENDOBRONCHIAL BLOCKING

Time	Monday	Tuesday	Wednesday	Thursday	Friday
9:00 a.m.	REGISTRATION	Anatomy of lower respiratory tract, including broncho-pulmonary segments and bronchoscopic views	Pathology of respiratory tract	Indications for preparation of patients and complications	Special problems — foreign bodies, etc.
10:00 a.m.	WELCOME ADDRESS Purpose and Scope of Course	Physiology of respiratory tract	Microbiology, including secretions-bacteriology, spectrum, etc.	Techniques and instrumentation	Tracheostomy
		Coffee Break — 20 Minutes			
11:30 a.m.	Anatomy of upper Respiratory tract including anomalies	Pharmacology of respiratory tract	Radiologic aspects, trauma, obstruction, foreign bodies	Nursing aspects a) Assisting b) Post-operative care c) Sterilization techniques	Anes. for laryngoscopy, bronchoscopy and endobronchial blocking and tracheostomy
12:30 p.m.			Lunch		
1:30 p.m.	Laboratory	Laboratory	Laboratory	Laboratory	
	Stress URT and larynx. Includes dissection period	Stress RRT and bronchoscopic anatomy. Includes dissection period	Bronchoscopy and endobronchial blocking	Review and practice	EXHIBITS
4:00 p.m.					

FIGURE 2

COURSE EVALUATION

Laryngoscopy, Therapeutic Bronchoscopy and Endobronchial Blocking Techniques

Please assist us in our course evaluation by answering the following questions frankly and in a constructive manner.

Please do NOT identify yourself in any way.

1) Do you feel that the course presented useful information?
2) Do you feel that other anesthesiologists would gain from taking this course?
3) Did you find the material presented to be related to the course description?
4) Please comment on the specific lecture sessions as to a) content, b) clarity, c) other comments.
   1. Anatomy of the Upper Respiratory Tract
   2. Anatomy of the Lower Respiratory Tract
   3. Dog Lab and Dissection — Larynx
   4. Dog Lab and Dissection — Tracheobronch Tree
   5. Physiology
   6. Pharmacology
   7. Microbiology
   8. Dog Lab — Blockers
   9. Nursing aspects
   10. Radiology
   11. Pathology
   12. Indications and Complications
   13. Techniques and Instrumentation
   14. Special problems
   15. Tracheostomy
   16. Anesthesia
   17. Exhibits
   18. Round Table Luncheon
5) Does this course fill a gap in the anesthesiologists training?
6) Would you recommend others to take this course?
7) Other comments:

choscopes, endobronchial blocking tubes of many types, and other instruments. Teaching aids included the Jackson-Huber model of the tracheobronchial tree and the bronchopulmonary segments as well as various models of the larynx, related audio-visual aids, and references.[3,4,5]

A total of 14 students participated in the pilot course. They included a general surgeon, an internist interested in chest diseases and a pediatrician. The balance were anesthesiologists. The class size was limited primarily by the practicalities of student-to-clinic subject ratio. The optimum ratio of 2:1 is difficult to achieve both as to subject and economics. Our group satisfactorily worked on a 3:1 basis.

Phase Three

At the conclusion of the program we entered Phase III of the program, namely — evaluation. We had already established the matter of interest and need. The students were asked to complete the course evaluation questionnaires (**Figure 2**). The results revealed the following:

1. A general agreement that the course should be extended to include additional topics, e.g., inhalation therapy aspects.
2. Additional clinical sessions should be provided to develop practice with man as the substrate in concert with our dog laboratory work.
3. The ratio of instructor to students in the laboratory should be increased to 1 instructor per 6 students.
4. At least 4 months' advanced publicity would enable students to program their other activities for the scheduled course time.
5. There was unanimous confirmation of
   a) a real need for such a program
   b) the basic scope of the teaching presentation.

In addition, the author noted a specific need for adequate secretarial, and other non-technical personnel to assist with the organization and conduct the mechanics of the course.

Conclusion

In conclusion, we presented a program in laryngoscopy, therapeutic bronchoscopy and endobronchial blocking techniques which was proven to be successful from all reviewed aspects. The weaknesses of the program were anticipated to some extent. In view of our experiences, the author is convinced that there is a present and continuing need and demand for a more intensive program. It is therefore planned to have a continuation of this type of project, coupled with investigations into the pathophysiology of these procedures.

Appreciation

The author wishes to express his appreciation to G. Dal Santo, M.D., Professor and Chairman of the Department of Anesthesiology, for his encouragement and support.

References

1. Kassay, D.: *Clin. applications of bronchology.* McGraw-Hill, 1960.
2. Beekhuis, G. Jan.: Elective tracheostomy — a training film. Wayne State University Audio Visual Production, 1964-65.
3. Dornette, Wm.: *Anatomy for the Anesthesiologist.* C. C. Thomas, 1963.
4. Jackson, C. and Jackson, C. L.: *Bronchoesophagology.* W. B. Saunders, 1950.
5. Mushin, W. W.: *Thoracic Anesthesia.* F. A. Davis Co., Phila., 1963.

Accidental Poisoning: Where Do We Go From Here?

BY GEORGE M. LOWREY, M.D.
MSMS ASSOCIATE SCIENTIFIC EDITOR

The incidence of accidental poisoning slowly but steadily increases in spite of efforts to prevent this.

The week of March 16-22 has been designated as a national "Poison Prevention Week." This will be the eighth time in as many years that such a week has been designated. Yet, in spite of short but intensive campaigns during this period, there has been a steady increase in the incidence of fatal poisoning.

National figures indicate that in the eight year period there have been approximately 15% more fatal poisonings on the basis of annual reports. Statistics published by the National Safety Council reveal that in 1967, 2,400 people lost their lives as a result of poisoning excluding those from gases and vapors. This represents approximately a 5% increase over the preceding 12 month period.

It thus appears that such short but intensive campaigns as exemplified by Poison Prevention Week, which are usually associated with radio and television programs as well as the passing out of pamphlets and placing of posters in store windows, are rather futile means of attacking the problem. Obviously one could say that conditions would be even worse if such campaigns were not used.

BY FAR THE MOST COMMON group of ingredients involved in fatal poisonings is medications, many available without prescription. Aspirin, sedatives and tranquilizers lead the list, in that order. The second group is cleansing and polishing agents, many of which contain volatile hydrocarbons as solvents or potent chemicals such as cyanide that are effective in removing metallic oxides. Other products frequently involved in poison cases are cosmetics and plants.

Within the past 10 to 15 years a number of actions have been taken to decrease the human toll caused by poisoning. One of these has been the establishment of a large number of poison information and therapy centers throughout the United States and Canada. A second has been the requirement of better labeling to indicate the potential danger of most household substances. This Federal law has been enforced for a little over five years but does not seem to have made a dent on the figures of the accident rate. Safety packaging for hazardous substances has recently been introduced. Finally, physicians together and individually have played an important role in this safety campaign.

THE EPIDEMIOLOGY of poisoning indicates clearly the *who, what* and *where* of the 2,400 fatalities. Discounting probable suicides, more than 75% of the fatalities occur in the preschool age group. This is an inquisitive and inexperienced population which accounts for their frequent tasting of unknown substances.

Any crowded living circumstance is conducive to an increased frequency of poisoning. It is well documented that this kind of accident occurs more commonly in lower income groups. The most frequent locations of poisoning within the home are the bedroom, the kitchen and the bathroom.

It is doubtful that purely educational means will ever eliminate all of the poisonings even though we understand the epidemiology. But these somewhat depressing facts should not lead to a decrease in the efforts of all of us to lessen the incidence of poisoning.

AT LEAST ONE important step that could be taken, however, is to increase the efficiency of poison information centers. It is apparent that at one time nearly every community hospital had a strong desire to establish such a center. It not only revealed their interest in the problem but also added somewhat to the prestige of the establishment.

Now it would appear that there are so many centers that there is an actual dispersion of knowledge and ability which might better be concentrated. The smaller centers simply cannot handle the mass of information necessary to do a creditable job. Frequently the personnel available work in the poison center only part time and therefore, their dedication and enthusiasm is difficult to maintain.

In a large center it would be possible to employ individuals who could devote full time to the problem. Consolidation would also eliminate expensive duplication. The larger centers could also explore untoward drug reaction and drug abuses both in and out of hospitals. It would be much easier to initiate a therapeutics committee of physicians, pharmacologists, pharmacists and other interested personnel in a consolidated center.

The present 500-plus poison control centers in the United States could easily be reduced to less than 100 more efficiently run and more reliable in furnishing information. Let us hope that the state of Michigan will soon take steps on this direction.

Diabetes and Pregnancy – Preliminary Report

By NANCY T. CAPUTO, M.D.
AND AGNA N. PINEDA, M.D.
DETROIT

Diabetes mellitus is a hereditary disease involving intermediate metabolism of carbohydrate, protein and fat. Due to a lack of effective insulin, there is a decrease in availability of cellular glucose and subsequent long-term degenerative changes in the vascular system of the body. Currently most investigators consider fasting hyperglycemia or even an abnormal glucose tolerance curve as a late event in the developing diabetic state.

Though most agree that diabetes manifests as an autosomal recessive trait, the genetic material inherited by the diabetic is unknown. However, one may observe the consequences of the genotype prior to orthodox phenotypic expression. The time from conception to inchoate loss of glucose tolerance (i.e. prediabetes) includes that period when the genotype exists without identifiable biochemical expression.

PREDIABETES PRECEDES chemical diabetes, that stage where no symptoms exist, a fasting blood sugar is normal, but the tolerance to glucose (with or without steroids, pregnancy, infection, or stress) is impaired. Chemical diabetes marks the "end of the beginning" in the unsuccessful battle to resist the development of diabetes and represents the earliest period in which diminished tolerance to glucose is demonstrable. We call the final stage symptomatic diabetes, acute or chronic, in which characteristic symptoms may exist associated with fasting hyperglycemia, glycosuria, and ketosis.

With the exception of obesity, one cannot control environmental and host factors which hasten the loss of glucose tolerance in the genetically-predisposed (prediabetic) patient. These factors include age (above puberty), sex (female greater than male) and parity. Some have proposed that pregnancy has a primary diabetogenic influence on the mother, and pregnancy complicated by hyperglycemia is diabetogenic to the child. Although most do not agree with this concept, a secondary diabetogenic influence on the infant cannot be denied.

Dr. Caputo is with the Department of Medicine, St. John Hospital, Detroit, where Doctor Pineda is a resident in obstetrics and gynecology.

Effects of Pregnancy

In pregnancy, the superimposition upon the maternal metabolism of an active protoplasmic mass which is predominantly anabolic, i.e., the fetus, requires compensatory integration of the available adaptive bio-chemical systems, especially those involved in energy production. The most obvious change is an increase in hormonal activity which accompanies gestation. Hypertrophy and hyperactivity of the pituitary, adrenal, thyroid, parathyroid, ovarian and placental hormonal elements occur normally. In addition there appears to be a reorganization of hepatic chemistry to maintain the appropriate energy transformations, release of intermediary metabolites, and regulation of the proper levels of active circulating hormones.

The metabolic adjustments induced by the increased demands of pregnancy are analogous to the adaptive changes which occur when any urgent requirement for energy is presented to the organism. Ordinarily, most energy needs can be provided by the normal carbohydrate bio-chemical sequences. However, gestational claims for energy require the augmentation of glucogenic mechanisms. These compensatory mechanisms include increased secretion of ACTH, growth hormone and thyroid as well as adrenal glucocorticoids. Each of these may be regarded as glucogenic and ketogenic factors which, in their activity, oppose insulin.

In the normal individual the increase in production of "contra-insulin factors" is compensated for by an increase in the secretion of insulin. However, the individual whose pancreas has an inherent defect cannot adapt adequately to the increased demand for sufficient insulin to counteract the effect of these elevated "contra-insulin factors." As a result, she may demonstrate this reduced capacity for adjustment by a reduction in tolerance for glucose and glycosuria.

SOME PEOPLE, under the provocation of stress and with the proper hereditary background, have changes in their ability to tolerate a glucose load.

These individuals are not diabetic by present standards and perhaps never will be. However, those falling behind in the insulin race today are more likely to become the diabetics of tomorrow. There is little doubt that the pregnant state may be diabetogenic. How this comes about is still conjectural, but it is known that the incidence of diabetes mellitus increases with parity.

The Study

We attempted to detect preclinical and florid diabetes mellitus in patients attending the prenatal clinic of Saint John Hospital from the period July, 1966 to present. A two-hour post-prandial blood sugar was done at the first visit and/or during the third trimester of pregnancy. Any patient with an abnormal two-hour post-prandial blood sugar had an oral glucose tolerance test. In our laboratory, diagnostic levels for the standard 100 gm oral glucose tolerance test using venous blood are: fasting: 110 mg per 100 ml, 1 hour: 150 mg per 100 ml, 2 hours: 120 mg per 100 ml, 3 hours: 110 mg per 100 ml. We consider the duration of the blood sugar elevation more important than the height of the peak.

From July 1966 to the present, 563 clinic patients had two-hour post-prandial blood sugars. Of these patients, the two-hour post-prandial blood sugar was abnormal in 69 (12%). 45 of these 69 patients had follow-up glucose tolerance tests, 35 of which were definitely abnormal, justifying the diagnosis of mild diabetes. Eleven of the remaining 24 patients with suspicious 2 hour post-prandial blood sugars are late in the gestational period and are scheduled for glucose tolerance tests post-partum. Of the 35 patients with impaired tolerance to glucose, 15 were primigravida, 13 secundagravida, seven were multigravida with only three having a parity of greater than four.

Twenty-one of the 35 had a positive family history of diabetes, but only four were obese with weights ranging between 160 and 200 pounds. Four patients had previous histories of large babies; all four were obese and their tolerance curves showed higher peak values than any of the others in the series. To date 33 of the 35 suspect patients have delivered per vaginam at term, while two patients had primary Caesarean sections because of contracted pelves. Four babies of the 35 weighed more than nine pounds at birth.

ALL PATIENTS WERE scheduled for repeat glucose tolerance tests six to ten weeks post-partum. However, only eight of these patients returned and of these, seven had normal glucose tolerance. The one patient with an abnormal test was an obese 19-year-old weighing 185 pounds who was delivered by Caesarean section and whose baby weighed 3900 grams. Post-partum glucose tolerance in this mother still showed a delayed curve compatible with mild diabetes. One further patient had a flat curve. We are attempting to improve on the followup studies in these 35 patients.

Conclusion

Five hundred and sixty-three patients attending a prenatal clinic had a two hour post-prandial blood sugar measured. 69 (12%) were abnormal. 45 of these (65%) had glucose tolerance tests, 35 of which were abnormal. Eight of those 35 had repeat tolerance tests six to ten weeks post-partum with only one abnormality.

Pregnancy is diabetogenic, though its demonstrated effect may be transient. Repeated diabetogenic stresses may lead ultimately to loss of glucose tolerance.

The Electrophoresis of Lipoproteins

JOHN G. BATSAKIS, M.D.
MARTHA M. THIESSEN, B.S. (ASCP)
ANN ARBOR

It is now well established that lipids in plasma exist almost entirely in a particular association with proteins, i.e., lipoproteins. In normal human plasma there are several species of lipoproteins, each differing in the nature of their protein moiety and in their relative content of the several classes of lipid. While there are perhaps a considerable number of lipoprotein species[1] only four have clinical portent to date; (1) *alpha* lipoproteins (high density), (2) *beta* lipoproteins (low density), (3) pre-beta lipoproteins (very low density) and (4) chylomicrons.

In 1965, Fredrickson and co-workers[2] devised a system for the phenotyping of hyperlipoproteinemia based on five major lipoprotein patterns as they were defined by paper electrophoresis and lipid staining of the electropherogram. Since then the five major patterns have been more clearly defined; one pattern (type III) has been re-defined and the clinical separateness of each has been preserved.[3]

The clinical usefulness of lipoprotein fractionation pertains at present principally to genetic studies and to the detection and therapy of the cardiovascular disease prone individual. Until recently the clinical laboratory could participate but little in these studies since quantitative alterations in the lipoproteins required analytical ultracentrifugation, a technique beyond the economic capacity of the routine hospital laboratory. The demonstration of clinically satisfactory separation of the lipoproteins by electrophoresis, however, places the hospital laboratory in the position of offering valuable assistance to both researcher and clinician. At present the lipoproteins are *most readily* demonstrated in the clinical laboratory by *electrophoresis* of serum or plasma samples.

Alternate electrophoretic technics

Despite the fact the widely used phenotypic classification of the hyperlipoproteinurias is based on information derived from *paper strip* electrophoresis and lipid staining of the lipoprotein complex,[4,5] considerable technological effort has been directed to find alternate electrophoretic technics. Requirements for any alternate method are (1) a reduction in total electrophoresis and staining time required in the paper electrophoresis technic (16-21 hours); (2) complementation and extension of the capabilities of paper strip technics; (3) avoidance of the variable degrees of absorption to filter paper and staining irregularities, thereby facilitating direct densitometric quantification of the lipoproteins and (4) the proposed alternative procedure *does not* require a revision of Fredrickson's classification.

Several electrophoretic media fulfill all or most of the aforementioned criteria. Agar and recently cellulose acetate each have their strong proponents. Cellulose acetate, particularly because of its widespread use as the electrophoretic medium for protein, hemoglobin and isoenzyme fractionation would appear to be a logical substitute.[6,7]

Complete lipoprotein resolution on cellulose acetate is achievable in 90 minutes (**Figure 1**). The results are directly comparable and interchangeable with those derived after standard paper-strip

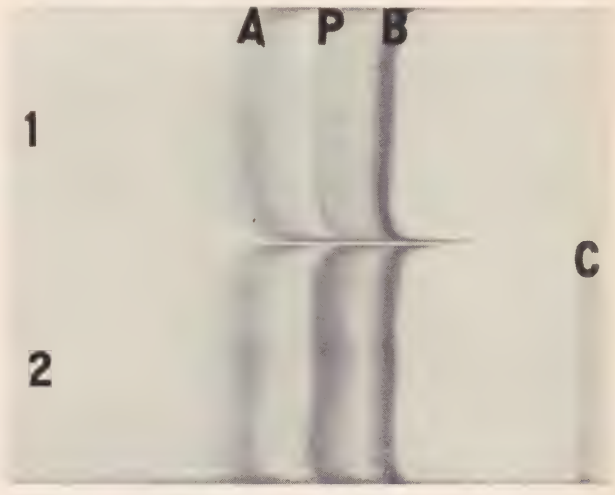


Figure 1: Stained lipoprotein electropherograms. Number I is from the patient in the fasting state; number 2 from the subject after a fatty meal. Note the appearance of chylomicrons (C) in the post-absorptive state. A represents the alpha lipoproteins; P, the pre-beta fraction and B, the beta lipoproteins.

The authors are both with the Department of Pathology, Section of Clinical Chemistry, the University of Michigan Medical Center. Their study was supported by a grant from the Michigan Heart Association.

electrophoresis; the relative magnitude of each lipoprotein fraction can be reproducably estimated by transmission densitometry; quantitative elution of the lipoproteins is facilitated; intact chylomicrons can be recovered by ultrasonic treatment; the technic does not require the presence of albumin in the buffer to enhance sharpness of separation; and the staining may be either by direct (lipid)[6] or indirect (Schiff's) [7,8] means.

The technic currently used in the Clinical Laboratories of the University of Michigan Medical Center is graphically illustrated in **Figure 2**, and the procedural steps are detailed at the end of this report. Accurate identification of all of Fredrickson's phenotypes has been accomplished and therapeutic guidelines for the hyperlipidemic patient enhanced by the use of this form of electrophoresis.

Finally, while rough estimations of the lipid content of the serum or plasma may be made by the inspection of the lipoprotein electropherogram, accurate qualification of the total serum

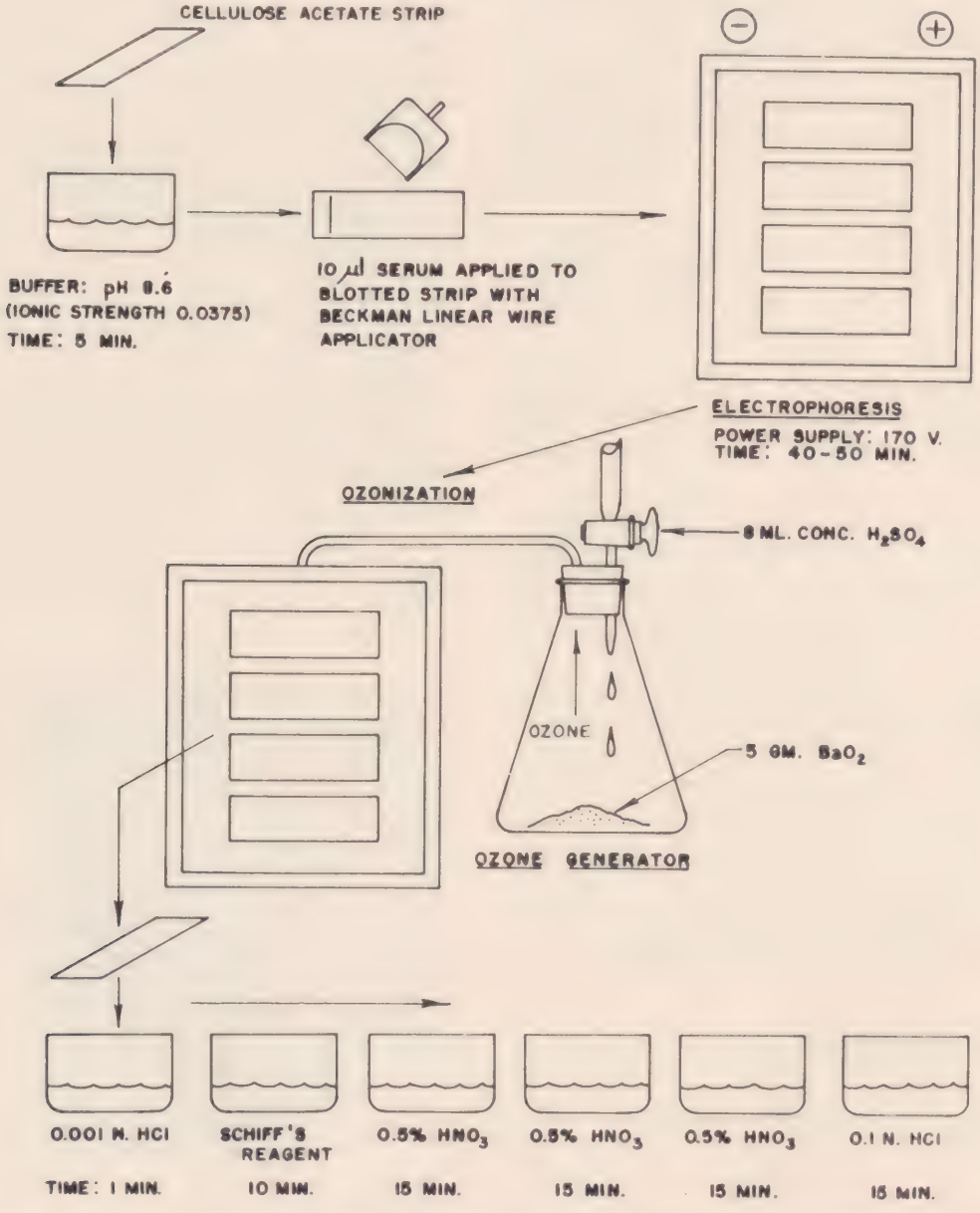


Figure 2: Schematic "flow diagram" for the lipoprotein electrophoresis procedure outlined at the conclusion of this report. The electrophoretic medium is cellulose acetate and staining of the lipoproteins is accomplished by an indirect (Schiff) technique after ozonization.

cholesterol and triglyceride content must complement the electrophoresis. Estimations of the total serum lipids do not serve as a substitute, nor does the estimation of the cholesterol esters add any meaningful data. Both of these measurements appear to have a limited life span in the clinical laboratory.

LIPOPROTEIN PROCEDURE

Material and Methods

REAGENTS

Buffer: Barbital-Sodium-Barbital buffer, 0.05 M, Ph 8.6

Stain: Schiff's reagent

Rinse solution:

(a) .001N hydrochloric acid
(b) 0.01N hydrochloric acid
(c) Nitric acid, 0.5%

OZONIZATION REAGENTS

(a) barium peroxide, anhydrous
(b) concentrated sulfuric acid

EQUIPMENT

1. DC-regulated power supply; any well-regulated power supply is suitable.
2. Electrophoresis chamber; Gelman "Cross-Channel"† rapid electrophoresis chamber.
3. Cellulose acetate membrane strips: Sephraphore III† 1 x 6 x 4 in.
4. Sample applicator; linear wire applicator (Beckman) .§
5. Flat-bottomed glass staining trays.
6. Ozonization chamber. This chamber may be readily fabricated from a glass chromatography chamber by placing a petri dish on the bottom and suspending the cellulose acetate membranes over the ozone generator. Air tight seal is requisite.

† Gelman Instrument Co., Wagner Road, Ann Arbor, Michigan.

§ Beckman Instruments, Inc., Fullerton, California 92634.

PROCEDURE

Cellulose acetate membrane strips are soaked in the buffer solutions for 10 minutes, and then gently blotted prior to the application of sample from a subject who has completed a 12 hour fast. Application of a 15 ul. serum sample (wire-linear applicator) is performed with the membrane strip placed on several thicknesses of blotting paper. The membrane is then immediately transferred to the electrophoresis chamber and electrophoresis is carried out for 90 minutes at a constant voltage of 300V and 1 ma. per strip.

Following electrophoresis, the membrane strips are removed and placed into the ozonization chamber where they are suspended over a petri dish containing approximately five grams of barium peroxide. Ozonization starts after the addition of 15 ml. concentrated H_2SO_4 into the petri dish. The chamber is sealed and ozonization permitted to continue for 10 minutes. The strips are then removed from the chamber and washed for one minute in .001 N HCl. Staining of the lipoprotein fractions is accomplished in a flat-bottomed staining receptacle containing Schiff's reagent where they are immersed for 15 minutes. After staining, three consecutive rinses or "washes" are performed; twice for 15 minutes each in 0.5% HNO_3 and once for 15 minutes in O. 1N HCl.

The membrane strips may be air-dried or the drying time reduced to one hour by placing the strips in 37°C drying oven.

Should densitometric quantification be desired, the dried membrane strip can be cleared and mounted on a glass microscope slide to facilitate scanning. The technique for clearing the membrane strips using glacial acetic acid, 10% (v/v) in 95% methanol (v/v) has been described elsewhere.[9]

References

1. Wurm, M., and Strauss, R.: Characterization of human serum protein and lipoproteins. *Amer. J. Clin. Path.* 50:175-193, 1968.
2. Fredrickson, D. S., and Lees, R. S.: A system for phenotyping hyperlipoproteinemia. *Circulation* 31: 321, 1965.
3. Levy, R. I., and Fredrickson, D. S.: Diagnosis and management of hyperlipoproteinemia. *Amer. J. Cardiology* 22:576-583, 1968.
4. Fredrickson, D. S., Levy, R. I., and Lees, R. S.: Fat transport in lipoprotein — an integrated approach to mechanisms and disorders. *New Eng. J. Med.* 276: 148-156, 1967.
5. Lees, R. S., and Hatch, F. T.: Sharper separation of lipoprotein species by paper electrophoresis in albumin-containing buffer. *J. Lab. Clin. Med.* 61:518-528, 1963.
6. Chin, H. P., and Blankenhorn, D. H.: Separation and quantitative analysis of serum lipoproteins by means of electrophoresis on cellulose acetate. *Clin. Chem. Acta* 20:305-314, 1968.
7. Farber, E. R., Batsakis, J. G., Thiessen, M. M., and Giesen, P.: Lipoprotein electrophoresis: A comparison of cellulose acetate and paper technics. *Amer. J. Clin. Path.* (In press.)
8. Kohn, J.: A lipoprotein staining method for zone electrophoresis. *Nature* 189:312-313, 1961.
9. Briere, R. O., Golias, T., and Batsakis, J. G.: Rapid qualitative and quantitative hemoglobin fractionation; cellulose acetate electrophoresis. *Amer. J. Clin. Path.* 44:695-701, 1965.

HEW Study Just Released Concludes Chiropractors Can't Provide Quality Care

BY M. A. RILEY
MSMS LEGISLATIVE COUNSEL

In a long-awaited study just released by the U. S. Department of Health, Education and Welfare, it is recommended that Congress continue the exclusion of chiropractic services under the Medicare program. Former Secretary of HEW Wilbur Cohen, in reporting this recommendation to House Speaker John McCormack says that this conclusion was reached because of the inability of this practitioner group, "as a result of education and basic approach," to give quality care.

Congress, early in 1968, directed the former Secretary of HEW to make a study relating to the inclusion, under the supplementary medical insurance program (Part B of Medicare), of additional types of licensed practitioners performing health services in independent practice. One of these "additional types," chiropractors, had mounted a concerted effort to gain acceptance by Congress as a Medicare health service provider.

SECRETARY COHEN'S LETTER transmitting the 250-page study to Congress declared that every effort had been made to assure practitioner groups under consideration that their demands for coverage would receive unbiased and impartial deliberation.

Seventy pages of the HEW study are devoted to chiropractic, and "leading chiropractors" throughout the country are quoted at length, as are chiropractic textbooks. Researchers concluded that they had "grave doubts about the basic preparation of chiropractic school graduates, despite the titles of the courses offered by the schools."

The report additionally states that (1) chiropractors either ignore or take exception to much scientific knowledge, (2) there is no valid evidence that a "subluxation," if such exists, is a significant factor in the disease processes and thus the chiropractic emphasis on analysis and treatment of "subluxations" is not justified, (3) chiropractic education is inadequate and thus it is unlikely that a chiropractor can adequately diagnose, and (4) while manipulation may be a valuable technique "for relief of pain due to loss of mobility of joints," research in this area is also inadequate.

THE FINAL HEW RECOMMENDATION reads as follows: "Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment. Therefore, it is recommended that chiropractic service not be covered in the Medicare program."

The HEW report was made public in December of 1968. In the January, 1969 issue (Volume 2, number 88) of the *Senior Citizens News*, published monthly in Washington, D.C. by the National Council of Senior Citizens, the centerfold pages are entirely given over to a lengthy article entitled "Why Chiropractic Cult Cannot Provide Quality Health Care!" The National Council had vigorously opposed inclusion of chiropractic services under Medicare when the issue came before Congress in 1968.

A listing of the sub-headings in this article serves to summarize its total contents: Chiropractors propaganda efforts — Get the facts — Chiropractors reject science — And Science rejects Chiropractic — "Straights" and "Mixers" — Poor instruction and training — Protective power of licensure — Supreme Court ruling — Exams do not qualify doctors — Phony machines — and More Politics than science. The article ends with this sentence: "With Chiropractic and other completely unscientific cults, there is no possibility for quality health care."

IN MICHIGAN, where chiropractors are pressing the Michigan Department of Social Services for reimbursement (under Medicaid) for two hundred and ninety-two (292) separate physicians' services for which doctors of medicine are presently reimbursed, the State Attorney General had just ruled that the term "doctors of medicine" as used in the Blue Shield Act of 1939 "does not include doctors of chiropractic medicine."

As the HEW comprehensive study points out, chiropractors are specifically licensed in 45 states, although in most they are widely restricted as to treatment methods permissible. "Licensure," says the study, "generally is considered a means of protection for the public, rather than official recognition of the licensee."



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

No two women are quite alike...





and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

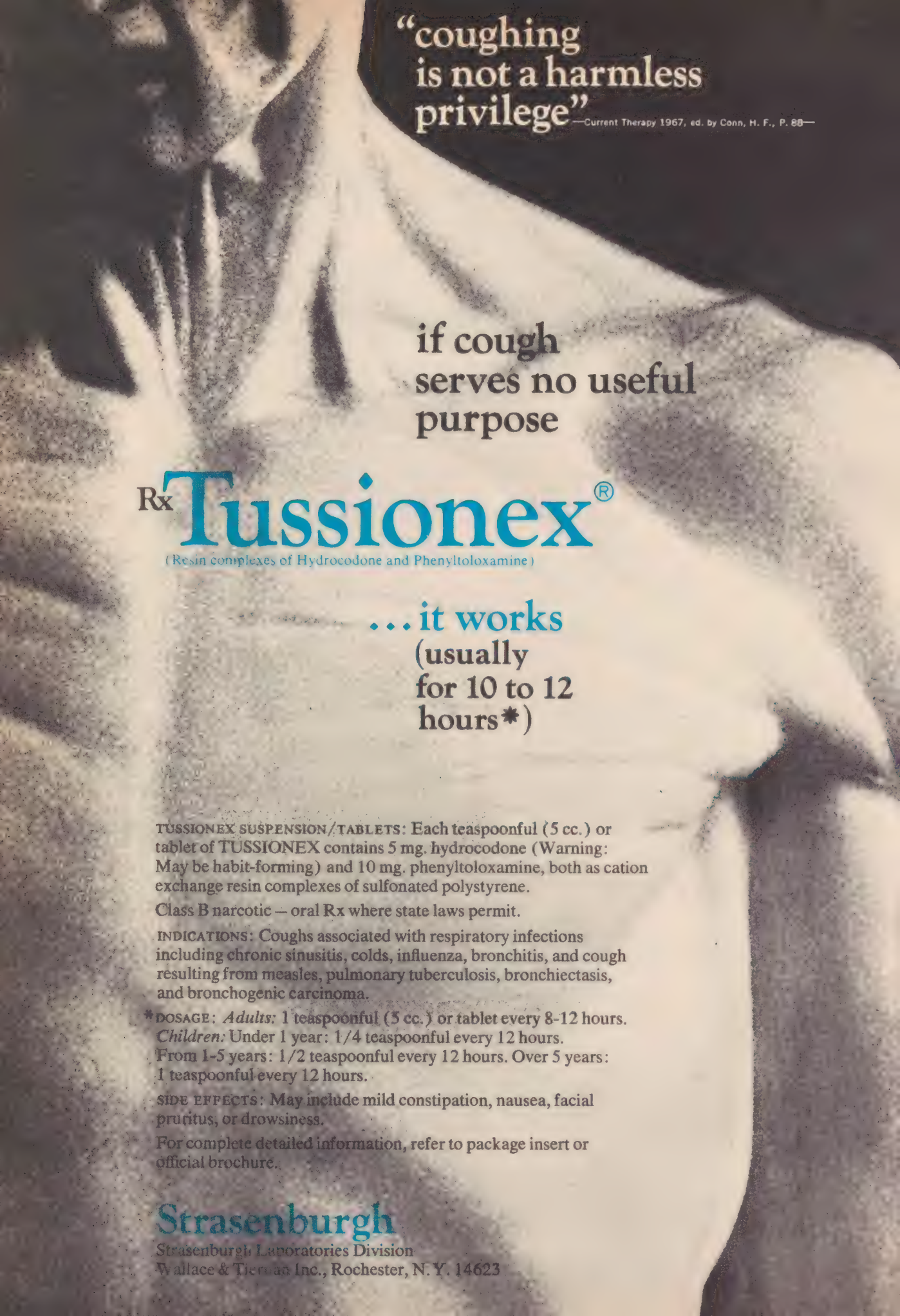
Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. *2*:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. *2*:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680



TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y. 14623



Michigan's 44th Governor,
WILLIAM G. MILLIKEN

Meet William Milliken, Michigan's New Governor

BY JUDITH MARR
MANAGING EDITOR

Michigan's new Governor has made his first move in medicine's direction through his initial State of the State message to the legislature. He asked for funds to be appropriated to support Schools of Medicine at the University of Michigan and Wayne State University and to develop Michigan State University's College of Human Medicine into a full four-year school.

But beyond that there is little yet for the state's medical personnel to use in sizing up the effect William Grawn Milliken will have on their programs and goals.

Perhaps clues may be gathered from a look into Governor Milliken's background, experiences and life history.

There are the vital statistics: Governor Milliken was born at Traverse City March 26, 1922, of a family in the mercantile business there since the 1870's; was graduated from Yale University; flew 50 combat missions as waist gunner on a B-24 in World War II; married the former Helen Wallbank of Denver, a Smith College graduate, and is the father of two children, Bill, Jr., and Elaine.

Then there is the man for which the statistics stand.

At the age of 46, he is so boyishly handsome and easy-going that detractors have called him "too nice" to be an effective Governor. "But," writes Elmer E. White of the Michigan Press Association, "many Milliken watchers say his mild appearance belies a deep toughness. They say he operates quietly but firmly and with strong conviction."

CERTAINLY, THAT OBSERVATION jibes better with the inscription printed beneath his graduation photo in the high school yearbook. His high school friends chose to remember him as "One part manners, one part wit, one part honor, the rest pure grit."

That opinion must be shared by the men who served with him during the war. Milliken was wounded in the stomach by flak during the return trip from a bombing mission over Vienna, was carried unconscious from the plane at the base and placed in a hospital, but reported for duty on the next bombing raid. He was awarded the Purple Heart, the Air Medal with two Oak



THEN-LT. GOV. Milliken paid a surprise visit to high school Red Cross Youths preparing Easter baskets for Michigan youth who were victims of spring tornadoes in the state.

Leaf Clusters and the European ribbon with three battle stars.

Governor Milliken's hobbies include skiing, gardening, swimming and tennis, which he enjoys with his family from their spacious home overlooking Grand Traverse Bay. Mrs. Milliken, incidentally, is enrolled in MSU's School of Landscape Architecture.

"He brings the astuteness of a successful businessman to the Governor's office," writes Elmer White. Governor Milliken took over the family department store at age 22 and built it into a major Michigan chain with outlets in Traverse City, Cadillac and Manistee.

HE ENTERED PUBLIC LIFE at age 25 when Gov. Kim Sigler appointed him to the State's Waterways Commission. He later served as Grand Traverse County Republican Chairman for six years.

Writer White also notes that capitol observers expect Milliken to be more of a team player than Romney, less emphatic about imposing his views on others and more diplomatic.

As a state senator (he was elected in 1961, following in the footsteps of both his father and grandfather, who were state senators) Milliken championed liberal causes: civil rights, expanded mental health services, more state aid for education and revised aid for the jobless. He was Majority Floor Leader his last two years in the Senate.

HE'S HAD MUCH experience at his job and had a long acquaintance with politics. Other advantages he can count on his side include a state treasury surplus, a public used to a now-year-old income tax, and an infectious charm.

Bill Milliken came into leadership in Michigan riding the crest of a change in which younger and impatient Republican moderates were rising to the fore.

"I don't believe civility is a sign of weakness," he says to charges that he is too soft. "And if I have to I can knock anybody's head. I can take whatever action is necessary."

Thus, Elmer White, executive secretary of the Michigan Press Association, writes of "a quiet intensity to Milliken — almost a grim determination to push through barriers and obstructions, to get the job done."

U-M Study Reveals Racial Differences In Medical Care

The following statistics in the health field, just released, were compiled during a research study in 1964 of 1,457 Detroit area aged residents by Prof. Benjamin J. Darsky, of the U-M department of medical care organization, and by Researcher H. Ashley Weeks:

Whites tended to put off medical care because the illness was "not bothering them" or was "not serious."

Negroes reported relatively more illnesses and tended to put off needed medical care for financial reasons.

In general, Negroes and whites reported the same kinds of illnesses, but Negroes reported a higher rate of hypertension, genito-urinary, and musculoskeletal problems whereas white had a higher rate of circulatory diseases.

Both Negroes and whites reported fewer illnesses as their incomes rose. The annual median income for Negro couples was approximately $2,765, compared with $3,735 for an aged white couple.

More whites had at least some health insurance, and Negroes were more likely to depend on welfare for medical care.

One fifth of all Negroes who received medical care had the expenses paid for either by Old Age Assistance (OAA) or Medical Assistance to the Aged (MAA) programs. Not more than one in 20 of all the whites reported that their medical care was paid for by welfare.

More whites had continued working in some capacity after age 65.

The Darsky-Weeks study has been published as "The Urban Aged — Race and Medical Care," by the University of Michigan. The men hope to make a similar study now that Medicare is in effect and compare the findings of the two surveys.



Dear Doctor, You made me what I am today a whole lot slimmer!

TEPANIL —the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Contraindicated concurrently with MAO inhibitors, in patients hypersensitive to diethylpropion hydrochloride, and in emotionally unstable patients known to be susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use great caution when prescribing for patients with severe hypertension or severe cardiovascular disease. Should not be used during the first trimester of pregnancy unless potential benefits outweigh potential risks.

Side Effects: While rarely causing therapy to be withdrawn, side effects may occur occasionally; CNS effects (such as insomnia, nervousness, jitteriness), dryness of mouth, thirst, nausea, abdominal distress, constipation, headache, allergic response including urticaria or other dermatitis; rarely associated with tachycardia, cardiac arrhythmia or ECG changes.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger.

Use in children under 12 years of age is not recommended.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

T817A U.S. PATENT NO. 3,001,910 1/69

Participation in MVF: A Time for Reflection

BY JOHN M. WELLMAN, M.D.
CHAIRMAN OF THE BOARD
MICHIGAN BLUE SHIELD

The Publication Committee of The Council of the Michigan State Medical Society requested Blue Shield to prepare a series of articles regarding our new Michigan Variable Fee (MVF) Program. The first two articles covered the MVF payment mechanism and the benefit structure of the new contract.

This, the third in the series, will dwell primarily on participation in the MVF Program by the members of the medical profession. It contains a philosophy which, I hope, will stimulate some personal reflection on the part of readers.

THE TONE OF THIS ARTICLE would be somewhat different if the present formal indications of support by the members of the medical profession were greater. We have come a long way in our participation campaign which began more than a year ago and we do appreciate the added support that has occurred. Participation is now at about the 69% level overall compared to our starting point of about 54% when the program began.

I feel, however, that until MVF has the formal support of the vast majority of the profession — 80% to 85% — we cannot really demonstrate to the profession or to the subscribers and the public in general what program we really have to offer.

It is difficult for me, a practicing physician, to understand the reluctance of some physicians to commit themselves to this program. I know there will always be that small group of practitioners who will reject any program no matter what or how good it may be. This is true for any type of program in any segment of society. I would be the first to suspect something was wrong if we had 100% participation. Some Blue Shield Plans do have close to total participation, but often only because such Plans do not pay anyone for services performed by non-participating doctors. This Michigan Blue Shield is reluctant to do.

The profession should be able to voluntarily improve considerably its participation. May I explain the "why" of my statement.

What insurance company asks the medical profession to supply 60% of the members of its Board of Directors? For that matter, what insurance company asks the medical profession to elect its entire Board of Directors? Blue Shield does!

WHAT INSURANCE COMPANY provides a state-wide network of voluntary Medical Advisory Committees selected entirely by the medical profession itself to review and adjudicate unusual or disputed cases? Blue Shield does! Blue Shield assumes the cost for any expense involving any such committee activity and is willing to abide by the decisions of such committees so long as the activities are based on the facts of each situation and so long as the committee will support Blue Shield if the decision is against the individual physician and in favor of the patient.

What insurance company goes to great lengths and considerable expense (over one million dollars in 1968) to provide trained and experienced representatives and educational coordinators to provide service and information directly to the profession on a firsthand basis in order that the profession can better understand and receive the benefits of a program which it itself created? As before, Blue Shield and only Blue Shield does!

What insurance company goes to the medical profession for suggestions and ideas on what kind of voluntary prepaid program is best for the public which the profession serves? Blue Shield does! As has been stated and written many times in the past two years, the MVF Program was designed with the best information available from the grass roots as well as the leadership of organized medicine. The benefit structure and the payment mechanism were formulated only after careful and close consultations with the medical profession at all levels.

Blue Shield also considered the needs and suggestions of the consumer and the general public in designing the MVF Program because, after all, they pay for the program and, therefore, should also have something to say about what it contains and how much it will cost. Throughout the development, however, the medical orientation of the program was kept paramount to provide the best possible health care program in Michigan for a reasonable price in a manner equitable to the profession, the public and Blue Shield.

JUST WHAT MUST BLUE SHIELD DO to satisfy those members of the profession who still apparently are not convinced of our motives? Certainly there are problems. However, little is accomplished through a "wait and see" or "I told you so" attitude. MVF has been a monumental change in Michigan Blue Shield history in terms of content and degree of change. It has not been easy and we didn't expect it to be when we began. There have been problems and there will be others. But they are minor, relatively speaking, and

should not be used by our critics to "knock" the entire program and process.

We began our MVF participation campaign with a personal letter to every physician in this state requesting his participation and support. Once again, I ask each of you, who has put aside his decision, to carefully reflect on its long range implications not only to himself personally but to Michigan Medicine in total. You know, if we all decided to wait and see or to not participate in the program, there would be no Michigan Blue Shield and the practice of medicine in Michigan might be quite different than as we now know it.

Because of the rather slow progress in improving physician participation, the Board of Directors is now compelled to face a decision which might have been avoided had the results to date been more satisfactory.

THE QUESTION IS – whether or not to continue to permit "per case participation" by non-participants. Our problem is one of equity.

On one hand, there is evidence that many doctors are taking advantage of the "per case" situation – participating only in those cases where they feel payment by the patient is questionable. On the other hand, some physicians, who signed up with MVF, are asking why Blue Shield lets non-participants have all the advantages and none of the obligations of participation.

The voluntary health care field is becoming more and more competitive. The customer is much more sophisticated in the technical aspects of the business. Rising costs are sharpening the attitude of buyers. The unique relationship that only Blue Shield possesses with the medical profession – i.e., participation – is being challenged, especially because physician charges and Plan costs are rising.

THE CUSTOMER IS NOT INTERESTED in casual or vague statements from Blue Shield about doctor support and medical orientation. He wants to know specifically what he can get in terms of delivery of the benefits he purchases. The only meaningful thing he recognizes in this regard is a formal and full commitment by the doctor. He doesn't want to take a *chance* that the bill will be paid in full – he wants assurance in advance. The only way Blue Shield can give him such assurance is by the participation agreement, and when one considers that a physician can cancel his participating agreement on fifteen (15) days notice, it certainly can't be said that the agreement freezes the doctor into any irrevocable commitment nor that the doctor is losing his freedom.

Therefore, to those of you who are "waiting to see," I suggest that you reassess the advantages of formal participation in your Blue Shield Michigan Variable Fee Program and forward your participation agreement to us so we can count you on our side.

U-M Ophthalmology Dept. Gets Blindness Grant

The University of Michigan Department of Ophthalmology has received its eighth grant from a national organization, Research to Prevent Blindness, to continue studies of eye pathology.

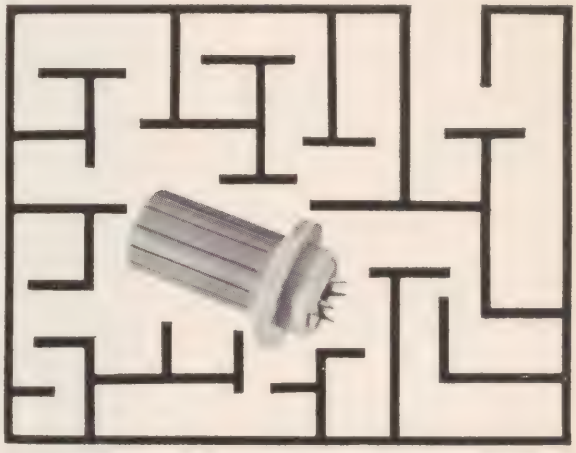
John W. Henderson, M.D., chairman of the department, said the $5,000 grant "has maximum flexibility and can be moved quickly into any area of scientific need or opportunity."

The grant will help support the eye pathology laboratory which provides diagnostic reports on eye disorders to doctors throughout Michigan, the Midwest and parts of Canada.

NEW MSU OFFICE PLANS REGIONAL MEDICAL PROGRAMS

Michigan State University's College of Human Medicine has opened a new Office for Regional Medical Programs, which will concentrate on planning for improved health care for victims of heart, cancer, stroke and related diseases.

Program director is Neil F. Bracht, also assistant dean in charge of community programs for the College of Human Medicine. L. George Suhrland, M.D., is project director and Ronald Richards, Ph.D., assistant project director.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9

Symbols in a life of psychic tension

B.A.
cum laude

V.P.
at thirty-two

ECG
and complete examination normal (persistent palpitations)



Rx

Valium® (diazepam) *t.i.d.* and *h.s.*

B.A. (*cum laude*)...V.P. (at thirty-two)...symbols that illuminate the quality of a life...the satisfactions of achievement, as well as its price...the pressures and stresses that can often create cardiac manifestations of psychic tension. For this kind of patient—with no demonstrable pathology—consider the singular benefits of Valium (diazepam).

With its pronounced calming action, Valium can relieve psychic tension promptly, attenuating its somatic signs and symptoms. Further, Valium is distinctly useful when somatic and depressive symptomatology (secondary to psychic tension) coexist. And Valium is generally well tolerated; in proper maintenance dosage, it seldom dulls the senses or interferes with functioning.

When psychic tension-related insomnia appears, an *h.s.* dose added to the *t.i.d.* schedule helps promote sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets *t.i.d.* or *q.i.d.*
to help relieve psychic tension and its somatic symptoms

ROCHE
Roche LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Doctor, This is WA-SAMA

By MRS. C. E. CROOK
LIAISON, AUXILIARY TO MSMS AND
MICHIGAN CHAPTERS OF WA-SAMA

Yesterday I telephoned my doctor husband, said one sentence, "Can't you come for dinner just *once* when you say you will?" — and slammed down the receiver. Would you believe it? Wow!!

I had learned years ago from my dear mother and from personal experience as a doctor's wife that such tactics are useless. Guess I'm just confessing that once in awhile we wives blow our cool. Perhaps I never would have made the call if there had been a WA-SAMA chapter for me when my husband was a medical student.

When my dad graduated from medical school in 1908, he was one of 3 married students in his class. In my husband's class there were 15 married students. As of this date, at the U of M Medical School, there are 102 senior medical student's wives who will be clutching their PHT (Putting Hubby Through) Degrees to their bosoms while they proudly hear their hubbies receive their M.D.'s This scene will be repeated all over the country. WA-SAMA today exceeds 60 chapters with more than 6,000 active members. In Michigan we have a chapter at each of our 3 medical schools.

The Woman's Auxiliary to the Student American Medical Association, represented by the initials, WA-SAMA, is an organization of the wives of medical students, interns and residents. It was formed to provide a continuing relationship and acquaintance with the aims, purposes and ideals of the profession of medicine, its various organizations and auxiliaries and to prepare them to accept the responsibilities as wives of medical doctors.

WA-SAMA is associated through official liaisons with our Auxiliary to the AMA, our Auriliary to the MSMS and to our Auxiliaries in counties where there are WA-SAMA chapters (Ingham, Washtenaw, Wayne). Their programs and projects are growing with their organization. Nationally they have established a valuable "Housing Service." It was initiated to provide specific information concerning the type of housing a medical wife and her family desired in the area to which medical school, internship or residency took them. Last year, the service found "homes" for 500 families. There is a National Co-ordinator. There are regional and national officers, an annual National Convention and one or two regional meetings per year. WA-SAMA has an official publication issued six times annually.

Local chapters initiate their own projects and programs to satisfy the needs of the girls in the individual chapters. Programs include lectures and panels on such topics as, "Anesthesiology in Childbirth" — "Sex Education" — "How To Avoid The Divorce Courts" — "The Art of Herb Cooking" and "Tips on Decorating the Doctor's Office." They participate in many, varied community service projects. All of these experiences will be valuable to the communities in which the young doctors and their wives establish their medical practices.

Our MSMS has realized for some time the potential leadership that exists among the medical students and has been cooperating with and contributing to the Student American Medical Association. The Auxiliary to the MSMS is hoping to augment the intents of the Society by helping the wives of these future medical leaders. We would hope such encouragement, advice and assistance would be given, that the team image of the "Doctor and His Wife" which these young people take into their chosen communities would be of benefit to them personally, to their communities and to the medical profession.

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan — MU 5-8441

M. Leroy Barry, M.D.

Dan W. Everett, M.D.
Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

Two good reasons to specify LEDERCILLIN® VK

Potassium Phenoxymethyl Penicillin

1. It's a Lederle product.

2. Low price.

Tablets:
250 mg—100's and 1000's
For Oral Solution:
125 mg/5 cc—80 cc and 150 cc
250 mg/5 cc—80 cc and 150 cc

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York
9-7-1041/461-9

NEW



Read and Study; Complete Text Of Single Medical Practice Act

AN ACT to regulate the practice of medicine, to provide for remedies relating to the unlawful practice of medicine and to make uniform the law with reference thereto.

The people of the State of Michigan enact:

SECTION 1. (*Definitions.*) As used in this Act,

(1) "board" means the State Medical Board;

(2) "court" means a court of competent jurisdiction;

(3) "license" or "license to practice medicine," when not otherwise qualified, means a license to practice medicine in this state issued under section 6 or a license which under section 10 has the same force and effect as one issued under section 6;

(4) "medical school" or "school" means a school of medicine or a school of osteopathy;

(5) "person" means an individual;

(6) "medical profession" means the collective body of physicians;

(7) "physician" means a holder of a license to practice medicine;

(8) "the practice of medicine" or "to practice medicine" means

(A) to diagnose, treat, prevent, cure or relieve any human disease, ailment, defect, complaint, or other condition, whether physical and/or mental, by attendance or advice, or by prescribing, furnishing or using any drug, medicine or instrument, or by any device or means whatsoever, or

(B) to offer, undertake, attempt to do or hold oneself out as able to do any of the acts described in clause (A);

(9) "state" means a state, district or territory of the United States and includes the Commonwealth of Puerto Rico.

SECTION 2. (*Purposes and Policies.*) This Act shall be liberally construed to effectuate its purposes and policies which are

(1) to provide laws covering the granting and subsequent use of the privilege of practicing medicine, in the interest of the health, safety, and welfare of the public, and

(2) to promote uniformity in the law relating to the practice of medicine, and

(3) to further the objective of insuring that medical services rendered by licensed practitioners of medicine should be adequate and competent, and

(4) to provide legal protection against unauthorized, incompetent, or unethical practice of medicine.

SECTION 3. (*Name of Board.*)

(a) The State Medical Board is hereby created. The number of board members shall be determined by the relative number of doctors of medicine and doctors of osteopathy who are licensed to practice in Michigan. Board members shall be residents of this state. They shall be divided into two categories. The first category shall consist of 8 members of the medical profession appointed by the Governor from among individuals licensed to practice medicine and nominated by the Michigan State Medical Society, said nominations to consist of not less than 3 times the number of appointments to be made. The second category shall consist of 2 members of the medical profession appointed by the Governor from among individuals licensed to practice medicine and nominated by the Michigan Association of Osteopathic Physicians and Surgeons, Inc., said nominations to consist of not less than 3 times the number of appointments to be made.

The Governor shall appoint, before the first day of October of each biennial period, persons qualified as aforesaid, to hold office for 4 years from the first day of October next ensuing. Each member shall be appointed for a term of four years and until his successor is appointed and qualified, except that following the effective date of this Act, four members in the first category and one member in the second category shall be appointed for terms of 2 years and except that an appointment to fill a vacancy shall be for the unexpired term.

(b) The Governor, after written notice and public hearing, may remove any member of the board for misconduct, neglect of duty or such disability as renders him unable to perform the duties of the office. His replacement shall be appointed by the Governor from the list of nominees submitted by the Michigan State Medical Society or the Michigan Association of Osteopathic Physicians and Surgeons, Inc. dependent upon the affiliation of the removed member.

(c) The board shall elect from among its members a president and vice-president, each of whom shall hold office for a term of one year and until his successor is elected and qualified. The board shall also appoint an executive secretary who shall not be a member of the board. He shall be responsible to the board.

(d) Members of the board and the executive secretary shall be reimbursed for all reasonable expenses incurred in the performance of their official duties, and the executive secretary and

members of the board shall receive compensation for their services as provided by law.

SECTION 4. (*Powers and Duties of the Board.*)

(a) The board, subject to the provisions of this Act, may

(1) issue, limit, suspend and revoke licenses to practice medicine, otherwise discipline holders of licenses, and restore licenses that have been revoked.

(2) hold hearings and conduct investigations in connection with the issuance, suspension, revocation or limitation of licenses and in connection with other disciplinary action for which there is no appropriate review board,

(3) compel the attendance of witnesses, require the production of books and records, administer oaths, and take testimony and proofs in respect to any matter under inquiry before the board,

(4) in the event of the refusal of a witness to obey a subpoena issued pursuant to the authority conferred by clause (3) or to testify as directed by the board, apply to a court for an order directing compliance,

(5) conduct uniform examinations and investigations to determine qualifications of all applicants,

(6) provide for the registration of individuals licensed to practice medicine and maintain registries of such individuals,

(7) collect information concerning authorized and unauthorized practice of medicine,

(8) make rules and regulations, not inconsistent with law, necessary or desirable in carrying out its duties and covering matters within its jurisdiction,

(9) approve medical schools, hospitals and institutions for the purposes specifically referred to in this Act, and

(10) perform all other acts and make all other determinations necessary and proper in carrying out the provisions of this Act.

(b) A person aggrieved by a decision of the board may have an appeal from the decision under the provisions of Act 197, P.A. 1952, as amended, being section 3.560 (21.1) to 3.560 (21.10), inclusive, of Michigan Statutes Annotated.

SECTION 5. (*Unlicensed Practice; Penalties and Remedies Relating to Unlawful Practice.*)

(a) Under the circumstances described and subject in each case to the limitations stated, the following persons, though not holding a license to practice medicine, may engage in the following activities included in the practice of medicine:

(1) a medical officer of the Armed Services of the United States, of the United States Public Health Service, or of the Veterans Administration, holding a degree from a medical school but not licensed to practice medicine in this State, while engaged in the performance of his official duties;

(2) an individual authorized to practice medicine in a foreign country, employed by a public health service maintained by the government of the foreign country for the exclusive use of members of its merchant marine and members of its consular and diplomatic corps, while caring for such members in the performance of his official duties;

(3) an individual residing in another state or country and authorized to practice medicine there, who is called in consultation by an individual licensed in this State or who for the purpose of furthering medical education is invited by a medical school approved by the board or by the Michigan State Medical Society or by the Michigan Association of Osteopathic Physicians and Surgeons, Inc. or by one of their component societies to conduct a lecture, clinic, or demonstration, while engaged in activities in connection with the consultation, lecture, clinic, or demonstration so long as he does not open an office or appoint a place to meet patients or receive calls within this State;

(4) an individual authorized to practice medicine in another state or country or a medical officer described in clause (1) or an individual who meets the requirements of clause (5) of subsection (a) of section 6, while rendering medical care in a time of disaster or while caring for an ill or injured individual at the scene of an emergency;

(5) a student in training in a medical school approved by the board, while performing the duties assigned to him in a hospital under the supervision or direction of its medical staff;

(6) an individual appointed as an intern in a hospital approved by the board, to the extent required by the duties of his position or by his program of training, for a period of one year and for such additional period as the board, upon application, may determine to be necessary. Neither the intern nor the hospital shall receive any fee for his services from any patients during the period of such training;

(7) an individual holding a limited license issued under section 7 of this Act, to the extent authorized by the license;

(8) an individual holding a temporary, or a temporary annual, license issued under section 7 of this Act, to the extent authorized by the license;

(9) a person licensed under other laws of this State, to the extent authorized by his license;

(10) an individual administering a remedy or a diagnostic procedure, service, or device as specifically directed by a licensed physician.

(b) Except as provided in subsection (a), it is unlawful for any person to practice medicine in

this State without a license under this Act. A person convicted of violating this subsection shall be fined not more than $5,000.00 or imprisoned for not more than one year, or both.

(c) The Attorney General shall refer any complaint of unlawful practice received by him to the board.

(d) No action may be maintained for the breach of a contract involving the unlawful practice of medicine nor for the recovery of compensation for services rendered under such a contract.

(e) When an individual has been the recipient of services constituting the unlawful practice of medicine, whether or not he knew that the rendition of the services was unlawful,

(1) he or his personal representative is entitled to recover the amount of any fee paid for the services, and

(2) damages for injury or death occurring as a result of the services may be recovered in an appropriate action without any proof of negligence.

SECTION 6. (*Issuance of Licenses.*)

(a) an individual who applies for a license to practice medicine is entitled to receive a license upon paying a fee established by the board and satisfying the board that the applicant:

(1) is at least 21 years of age, and

(2) is a citizen of the United States, and

(3) is of good moral character, and

(4) has satisfactorily completed two years of general study in a college or university approved by the board, or the board finds that he has satisfactorily completed equivalent studies, and

(5) applicant has received the degree of Doctor of Medicine or the degree of Doctor of Osteopathy in a school approved by the board as of the time this degree was conferred, or, if applicant was lawfully engaged in practice as a Doctor of Medicine or a Doctor of Osteopathy after completing studies in an unapproved school, applicant received such post-graduate training in an approved school as the board may deem sufficient to satisfy the medical education requirement, and

(6) applicant has completed one year of post graduate training in a hospital or other institution approved by the board for such training, and

(7) applicant has passed an examination given by the board with a grade of not less than 75 per cent in each subject, or the board may accept in lieu thereof, proof that the applicant has successfully passed an equivalent examination approved by the board.

(b) An individual who is licensed to practice medicine in another State or territory of the United States and applies for a license in this State is entitled to receive a license upon paying a fee established by the board and satisfying the board that:

(1) applicant meets the requirements of clauses (1), (2), (3), (4), (5), and (6) of subsection (a), and

(2) that no state licensing board disciplinary proceedings are pending against him, and

(3) applicant was licensed to practice in another State after passing an examination deemed by the board to have been conducted in accordance with standards substantially equivalent to those applicable to examinations given by the board, or the board may accept in lieu thereof, proof that the applicant has successfully passed examinations approved by the board.

SECTION 7. (*Temporary and Limited Licenses.*)

(a) The board may issue a temporary license to practice medicine under the supervision or direction of a physician in a hospital or institution approved by the board to an individual who pays a fee established by the board and who satisfies the board that he meets the requirements of clauses (1), (2), (3), (4), (5) and (6) of subsection (a) of section 6.

(b) The board may issue a temporary annual license to practice medicine for those who possess all other qualifications for registration except that of citizenship in the United States, but who furnish evidence of having made a declaration of intent; such temporary annual licenses not to be granted for a period of more than 5 years.

(c) The board may issue a limited or regular license to practice medicine to a physician whose license has been revoked by the board. Practice under a limited license may be restricted to institutional, industrial, group practice, or practice under such conditions as may be set forth by the board. A limited license shall specify that the holder is licensed to practice medicine as prescribed by the board, but it shall not differ in any other particular from a regular license. Holders of limited licenses shall remain under the scrutiny of the board and shall make such reports as are set forth under the rules and regulations of the board. Any violation of the conditions under which a limited license is granted shall constitute cause for suspension or revocation of such license. At the discretion of the board, a limited license may be converted to a regular or unlimited license upon application of the licensee.

SECTION 8. (*Drugless Healers; Registration, Examination, Fee, Title.*)

The board is authorized to issue a license or certificate of registration to any person who desires to practice a system of treatment of human

ailments or diseases, and who does not in such treatment use drugs or medicines, internally or externally, and who does not practice surgery or obstetrics, under the provisions of this Act; Provided, that the applicant for such license or certificate of registration shall have a degree from an accredited college or university approved by the board, or an equivalent credential, and shall pass an examination approved by the board upon subjects designated by the board. This examination shall be concurrent with and equivalent to the examination provided for practitioners of medicine in these subjects under this act. The fee for such examination shall be set by the board. A practitioner under this subdivision shall not be permitted to use any form of the title "doctor" or "professor," or any of their abbreviations or any other sign or appellation to his or her name which would in any way designate him or her as a physician or surgeon. Any violation of these rules shall be cause for suspension or revocation of such license or certificate.

SECTION 9. (*Registration.*)

(a) Each person holding a license in this State pursuant to this Act shall apply for registration and shall be subject to reregistration for each subsequent calendar year that he intends to engage in the practice of medicine in this State.

(b) Upon receiving an application for reregistration and payment of the reregistration fee, the board, if satisfied that the applicant is licensed as stated in the application, shall issue to him the appropriate certificate of registration.

(c) The reregistration fee for each full year covered by the certificate of registration for a license issued under section 6 or a limited license shall be established by the board.

(d) Upon the termination of a ninety day delay in reregistration the license to practice medicine of such delinquent registrant shall be suspended until reinstated by the payment of a fee established by the board to the board.

(e) The holder of any license granted pursuant to this act who notifies the board of the withdrawal of his registration is not required to pay reregistration fees or penalties beyond those due at the time of his withdrawal, but after a holder gives such notice, his license to practice is not valid until reinstated by the board. An applicant for reinstatement is entitled to be reinstated upon paying a reinstatement fee established by the board and satisfying the board that he has paid all registration fees due at the time of his withdrawal.

(f) Each person who receives a certificate of reregistration under this section shall display it in his office at all times.

SECTION 10. (*Revocation and Restoration of Licenses; Disciplinary Proceedings.*)

(a) In all procedures before the board, the subject of such hearing shall have the right of legal counsel and a verbatim report of the hearing. The board shall explain to the subject his rights before proceeding with the hearing.

(b) In the event that the holder of any license to practice medicine granted pursuant to this Act, in a proceeding in a court in this or another State or in a Federal court, is adjudged guilty of a felony or is adjudged to be mentally incompetent or insane, his license and registration may be revoked, limited, or suspended and may be subsequently restored at the discretion of the board. If the court in which the adjudication takes place is a court of this State, it is the duty of the clerk of the court to transmit to the board a certificate of the adjudication. The board shall have the power to suspend the license of any licensee who has been tried in a court of competent jurisdiction and who has been found guilty of a felony pending the disposition of his case on appeal.

(c) The board, proceeding in accordance with Act 197, P.A. 1952, as amended being section 3.560 (21.1) to 3.560 (21.10), inclusive, of Michigan Statutes Annotated, may revoke, suspend, or limit any license and registration granted pursuant to this Act or it may reprimand the holder, upon any of the following grounds:

(1) conviction in a court of a foreign country of a nonpolitical crime which if committed in this State would constitute a felony;

(2) in the case of a holder of a license issued under sections 6 or 7, loss of United States citizenship;

(3) permitting his name or his certificate of registration to be used by any person, group, or corporation when the doctor concerned is not actually in charge of or responsible for the treatment given.

(4) such physical disability or mental incompetence or such addiction to drugs or intoxicants as to render the holder of the license unable to perform medical services with reasonable skill and with safety to the patient;

(5) willfully and intentionally assisting in the unlawful practice of medicine;

(6) advertising and/or practicing medicine in a manner determined by the board to be unethical according to the code of ethics of the American Medical Association and of the American Osteopathic Association;

(7) willfully and intentionally representing with the purpose of obtaining compensation or other advantage for himself or for any other person that an incurable disease or injury or other incurable condition can be permanently cured; or

(8) willfully and intentionally making a false and fraudulent statement or submitting a forged

document in applying for a license to practice medicine.

(d) The board in its discretion may at any time entertain an application for restoration of a license that has been revoked and grant a hearing thereon, and the board shall conduct such hearing within one year of the application therefore.

(e) The board may grant the restoration of any revoked license issued pursuant to this Act if after a hearing it is satisfied that the applicant:

(1) is of good moral character;

(2) is able to perform medical services with reasonable skill and with safety to the patient;

(3) should be permitted in the public interest to resume the practice of medicine; and

(4) is a United States Citizen.

SECTION 11. (*Licenses Previously Issued; Pending Proceedings.*)

(a) All licenses to practice medicine of the kind which may be issued under the provisions of this Act heretofore legally issued in this State and valid when this Act takes effect shall have the same force and effect as similar licenses issued under this Act, and such licenses are subject to the same authority of the board to revoke, limit, suspend or restore them as similar licenses issued under this Act. The holder of a license heretofore legally issued in this State is subject to the same disciplinary proceedings to which a holder of a license issued under this Act is subject.

(b) No proceedings to revoke, suspend or limit any license or otherwise to discipline the holder thereof shall abate by reason of the passage of this Act. The board may revoke, limit or suspend a license or otherwise discipline the holder thereof on account of any act or circumstance occurring before this Act takes effect, if such act or circumstance is a ground for such action under the provisions of the law in effect at the time of the act or circumstance and also a ground for such action under this Act.

SECTION 12. (*Short Title.*) This Act may be cited as the Single Medical Practice Act.

SECTION 13. (*Repealer.*) The following Acts and all other Acts or parts of Acts inconsistent with this Act are hereby repealed:

(1) Act 237, P.A. 1899, as amended;

(2) Act 56, P.A. 1905, as amended;

(3) Act 162, P.A. 1903, as amended;

(4) Act 59, P.A. 1937, as amended.

SECTION 14. (*Time of Taking Effect.*) (The legislature will determine the date the law will become effective.)

Increase Practice Control Through MANAGEMENT By

Modern office and financial management offers realistic methods toward achievement of personal life goals. A logical outcome of PM's services is the attainment of your objectives.

OBJECTIVES

- More Time for Patient
- More Time for Leisure
- Better Collection Control
- Better Cost Control
- Assistance With Financial Planning
- Identify Business Problems
- Seek Best Solutions to Problems

PROFESSIONAL MANAGEMENT
Black and Skaggs Associates, Inc.
Battle Creek, Michigan

Serving Michigan Physicians

Offices in these cities
Ann Arbor - Battle Creek - Berkley - Detroit - Flint
Grand Rapids - Lansing - Muskegon - Saginaw - Traverse City

PROFESSIONAL MANAGEMENT FOR PHYSICIANS AND DENTISTS
since 1932 PM®

The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

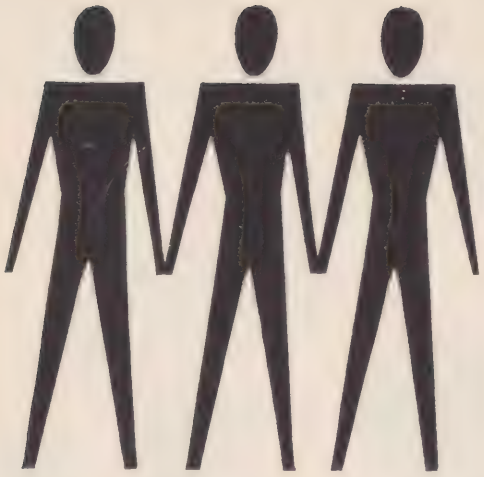
One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220

A·H·ROBINS



SOCIO-ECONOMIC

STATISTICS REVEAL STATUS OF HEALTH INSURANCE IN MICHIGAN

The 1968 Source Book of Health Insurance Data, published by the Health Insurance Institute, lists the following statistics on the progress of private health insurance in Michigan:

(1) Ninety-five percent of persons under 65 in the East North Central region, which includes Michigan, were protected by some form of health insurance in 1967.

(2) As of December 31, 1967, Michigan ranked sixth behind New York State, California, Pennsylvania, Illinois and Ohio for number of persons under 65 protected for various types of medical expense. 7.5 million in the state were protected for hospital expense, 7 million for surgical expense and 6.5 million for regular medical expense.

(3) Michigan ranked fourth behind New York State, California and Pennsylvania for the greatest amount of benefits received from insuring organizations in 1966 (latest year for which figures are available.)

(4) Payments, by type of insurer, totaled $661,224,000 in 1966, with $295,526,000 paid out by insurance companies, $365,698,000 by Blue Cross, Blue Shield and other hospital-medical plans.

(5) Michigan was sixth behind New York State, California, Illinois, Pennsylvania and Ohio in total amount of health insurance premiums paid in 1966. That amount is $766,356,000, with $378,275,000 of it paid by insurance companies and $388,081,000 of it paid by Blue Cross, Blue Shield and other hospital-medical plans.

(6) The number of insuring organizations writing health insurance in Michigan in 1966 breaks down into 338 insurance companies, Blue Cross, Blue Shield, medical society plans, and seven independent plans.

Doctor's Tax Calendar Through June, 1969

MARCH 17 — If contributions to employes' Social Security plus the Social Security and income taxes *withheld* from their salaries exceeded $100 in February, complete Form 501 and pay the taxes.

APRIL 15 — File Federal income tax return, Form 1040, and pay any balance still owed on income tax for 1968. Also complete Schedule C-3 and pay any remaining balance of 1968 Social Security tax of $499.20.

Doctors who practiced in partnership in 1968 should report their share of the earnings on Form 1040 and make sure the partnership files an information return, Form 1065.

This is the final date to file an estimate of 1969 income on Form 1040-ES and pay one-fourth of estimated Federal income tax for 1969 and one-fourth of 1969 Social Security tax of $538.20.

If contributions to employes' Social Security plus the Social Security and income taxes *withheld* from their salaries exceeded $100 in March, complete Form 501 and pay the taxes.

APRIL 30 — Pay the balance of first-quarter contributions to employes' Social Security, plus the 1969 Social Security and income taxes withheld from their salaries through March 31. File Form 941.

MAY 15 — If contributions to employes' Social Security plus Social Security and income taxes *withheld* from their salaries exceeded $100 in April, complete Form 501 and pay the taxes.

JUNE 16 — Pay the second installment of 1969 Federal tax (one-fourth of estimated income tax and one-fourth of 1969 Social Security tax of $538.20). If taxable income so far this year varies 10 per cent or more from original estimate, it's advisable to file an amended Form 1040-ES. (Use the quarterly payment form.)

If contributions to employes' Social Security plus the Social Security and income taxes *withheld* from their salaries exceeded $100 in May, complete Form 501 and pay the taxes.

PARKE-DAVIS PURCHASES MEDICAL INSTRUMENTATION FIRM

Parke, Davis & Company has acquired Medical-Technology, Inc., of Waltham, Mass, a medical instrumentation firm.

William G. Meier, Parke-Davis administrative vice president, said Medical-Technology would be combined with PanAura Corporation, acquired last year, and operated as the Medical Instruments Division of Parke, Davis & Company.

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.







Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, those cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.
Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.
Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.
Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000. Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B) R3-46-560-B

Under license from
Boehringer Ingelheim G.m.b.H.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals (Geigy)
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Preludin® Endurets®
phenmetrazine hydrochloride — prolonged-action tablets



They run a good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a natural curb on appetite and frequently promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

Mild ulcerative colitis may be triggered here...



or here.



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

ADVERSE REACTIONS: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Public Enema No.1





Claim the rewards of sparing your patients the tubes and tribulations of unpleasant enemas.

Compared to enemas, Dulcolax suppositories are a gentler and simpler way to empty the bowel. Gone are the tubing, the "accidents", and the bruised egos. Just one suppository, inserted against the bowel wall, usually brings about an evacuation within 15 minutes to an hour.

In the hospital, order Dulcolax for constipation or bowel cleansing. Your patients will often prefer it to embarrassing enemas. And you can be sure nurses will appreciate the saving in time and effort.

Dulcolax tablets taken at night usually result in a bowel movement the following morning. A combination of tablets at night and a suppository the next morning generally cleans the bowel thoroughly in preparation for surgery or special procedures. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable

bisacodyl



Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York 10502

DU-61



MORE THAN 400 REGISTRANTS from many parts of the United States, South America, Germany, Poland and Canada were on hand for the Wayne State University 17th Annual Blood Symposium. "Disseminated Intravascular Coagulation in Shock" was discussed by Robert M. Hardaway, M.D., second from left, Department of the Army, U.S. Army Hospital, Frankfurt, Germany. Others shown from left: Sidney Prystowsky, M.D., Bloomfield Hills; Herbert L. Davis, M.D., University of Nebraska College of Medicine, and O. H. Davis, M.D., Cincinnati.

WSU Symposium on Blood



Donald G. McKay, M.D., University of California School of Medicine, was introduced to the Symposium audience by Eberhard F. Mammen, M.D., Professor of Physiology and Pharmacology at the WSU School of Medicine.



CHAIRMAN OF WSU Physiology and Pharmacology, Walter Seegers, Ph.D., right, visits at the Blood Symposium with Speaker Hans G. Lasch, M.D., Department of Medicine, University of Giessen, Germany.



PEACE CORPS VOLUNTEER David W. Fricke, M.D., left, and an Afghan doctor examine 12-year-old Abdul who was injured when a firecracker exploded in his hand. Doctor Fricke, 33, is head of surgery at the 90-bed hospital of the Nangrahar Medical School in Jalalabad.

Michigan Doctor Serves in Afghan Medical School

Special To Michigan Medicine

Abdul didn't know about the statistics — 500 doctors for all of Afghanistan; half of them in the capital city; one for every 31,000 people. Abdul knew no statistics at all. He knew only that a giant firecracker had exploded in his hand and he wanted someone to make the pain go away.

The boy was taken from his village to the town of Jalalabad 30 miles away, to a small medical school that's helping to change the statistics. There, his hand was mended by an American volunteer physician and a strange new world entered his life.

The American is David W. Fricke, M.D., a MSMS member from Grand Rapids who is a Peace Corps Volunteer physician in Afghanistan. He is head of the surgery department at Nangra-



DOCTOR FRICKE looks over the shoulder of an Afghan surgeon as he assists with major operations at the Nangrahar Medical School hospital.



DOCTOR FRICKE lectures his class at the Nangrahar Medical School.

har Medical School, the smallest and newest of Afghanistan's two medical colleges.

TO ABDUL, Doctor Fricke and four other Peace Corps physicians at Nangrahar were comforting curiosities. But to the 265 medical students, the strangeness has worn off and the five Americans have become an integral, respected part of the schools.

The five physicians — the only Volunteer doctors in the Peace Corps — comprise nearly one-fourth of the faculty of the six-year-old school. They lecture, accompany interns on the rounds and help out with patients in the school's 90-bed hospital.

Doctor Fricke, for example, lectures 10 hours a week, spends several hours a day on the wards and assists with major operations.

"Conditions are improving a little bit every year," he observes. "But there's still a good deal of work to be done."

Eighteen months ago, Doctor Fricke and his family left Grand Rapids to go to Nangrahar and help do some of that work.

Since then, the 33-year-old University of Pennsylvania Medical School graduate has worked to "organize, lead and discipline" the surgery program at Nangrahar.

IT'S A TOUGH and sometimes frustrating life — trying to bring the scholarship and exacting standards necessary for medical study to students whose educational backgrounds have offered little preparation. "I tend to run out of patience," Doctor Fricke explains, not intending the age old doctor's pun, "but with experience I hope I can overcome that."

The school's equipment is adequate and the library is growing, he adds, and predicts that, overall, "things will improve around here."

In addition to the five doctors, the Peace Corps has sent three medical technologists, a radiologist, seven nurses and four English teachers to Nangrahar. All speak Farsi, Afghanistan's national language, all live in modest houses in Jalalabad and get by on small living allowances.

VOLUNTEERS HAVE SERVED — with considerable success — on the faculty at Nangrahar since 1964, the second year of the school's life. However, Doctor Fricke says that he's not sure the Peace Corps should continue to provide Volunteer physicians as faculty members.

"Most of us aren't from an academic background," he explains, "it would be much better if we could find doctors with teaching experience."

The Peace Corps and Nangrahar officials agree, and several other avenues of finding faculty members are being explored. (One strong possibility: a consortium with an American university).

As a result, the Peace Corps is concentrating almost exclusively on finding doctors to serve as staff physicians overseas. There are many differences between a Peace Corps staff doctor and Volunteer doctor, officials say, but the two largest are responsibility and salary. Volunteer doctors treat local people and receive $75 a month and a small living allowance. Staff doctors are responsible, primarily, for the health of the Volunteers and for health programming and are paid from $11,500 to $20,000 a year depending on experience, training and pre-Peace Corps earnings.

There are more than 100 staff doctors working in 59 countries in Africa, Asia and the Pacific, and Latin America.

PHOTOS AND STORY
BY DAVID SWANSTON
REGIONAL CORRESPONDENT
OFFICE OF PUBLIC INFORMATION
WASHINGTON, D.C.



REHEARSAL'S IN PROGRESS FOR the Feb. 9 installment of weekly "Formula" program aired over WJIM-TV. From left are Paul V. Placeway, Lansing, vocational rehabilitation counselor at the Michigan School for the Blind; Justin Sleight, M.D., Lansing ophthalmologist, Program Host Hugh W. Brenneman; and Helen Menton, producer of the Michigan Association of the Professions program.

OPHTHALMOLOGIST AMONG THREE ON "FORMULA" TV PANEL

The ophthalmologist should be the first to get the newly-diagnosed blind person to rehabilitative help, believes Justin L. Sleight, M.D., Lansing ophthalmologist.

He expressed the view while taping the MAP program, "Formula for Blindness," shown recently over WJIM-TV in Lansing. Doctor Sleight was on a panel of three interviewed by the host of the weekly Sunday evening "Formula" programs, Hugh W. Brenneman, MAP and MSMS executive director.

"I am one who strongly feels the parents of blind children need to know what the future holds," continued Doctor Sleight during the taping session. "The ophthalmologist needs to sit down with the parents to discuss what the problem is and what can be done about it.

"And there are some silver linings," he added.

Doctor Sleight tells parents of his own blind patients to treat the youngsters as much as possible like sighted children.

The best way to prevent blindness in adults, who most often suffer the condition as a result of glaucoma or diabetes, is through early diagnosis and treatment, said Doctor Sleight in response to questions. Blindness through hereditary causes can be prevented if doctors recognizing the hereditary trait in adults advise those adults not to have children, but rather to adopt if they do not want to pass on the affliction, he said. Care in preventing accidents to the eyes will also thwart blindness, he noted.



MR. BRENNEMAN HELPS adjust microphones of, from left, Mr. Placeway, Doctor Sleight, and Robert H. Thompson, Ph.D., superintendent of Michigan School for the Blind, prior to taping of the "Formula" show.

IN GLARE of bright lights, the Michigan Association of the Professions "Formula" program is taped at Lansing television studio.





Lester Bollwahn, coordinator of Emergency Medical Services for the Michigan Department of Health, left, talks with MSMS Highway Injury Committee Chairman Paul W. Gikas, M.D.

Committee Acts On Ambulances, State Medical Advisors

The MSMS Highway Injury Committee, at its Jan. 15 meeting:

1) voted to publish in *Michigan Medicine,* and to disseminate to component medical societies, informational material on the availability of Federal funds for purchasing equipment if a new ambulance service is initiated by a local community. Funds are also available for additional equipment and for training ambulance drivers and attendants.
2) reviewed a Michigan Department of State legislative bill to establish a medical advisory commission within State. The MSMS Legal Affairs Committee was requested to add a proviso "granting immunity to physicians for the voluntary or compulsory reporting of medical conditions which might adversely affect the driving task."

The Committee continues to express concern about lacking or sub-standard emergency medical service on highways in many sections of the State and seeks to improve accident detection, communications, initial care and transportation of the victim to lower mortality rates and improve weaknesses in the present system.

The committee heard Lester Bollwahn, coordinator, emergency Medical Services, Michigan Department of Health, describe a survey being initiated by the Department of Health to improve action reports of automobile accidents by law enforcement agencies and ambulance companies.

The survey will assist in complying with the new Federal Highway Safety Act of 1966 and will also form a basis for the ambulance inspection and licensing law to become effective July 1.

Frank DeRose, acting director, Office of Highway Safety Planning, discussed the funds available for community ambulance service, while Milo Chalfant, Traffic Safety Coordinator, Office of Driver and Vehicle Services, outlined the bill to establish the medical advisory commission.

Frank DeRose, left, acting director of the Michigan Office of Highway Safety Planning, and Milo Chalfant, Traffic Safety Coordinator, Office of Driver and Vehicle Services, Michigan Department of State, right, were guests at a recent meeting of the MSMS Highway Injury Committee, chaired by Paul W. Gikas, center.





THE FILM STRIP, "This Is Your Life," is shown to boys in sixth grade in Jackson to begin the school's sex education program, which was developed with the assistance of the Jackson County Medical Society, educators, and other authorities. Many physicians are advising schools on ways to improve their family-living units.



AT RIGHT, information for the **AMA News** articles about the need to expand the two-year MSU College of Human Medicine to a four-year school is obtained by William Spelbring, associate editor, from Andrew D. Hunt, Jr., M.D., MSU dean. Mr. Spelbring also talked to the other deans, community leaders and MSMS officials on a recent swing into Michigan.



TEACHING TECHNIQUES, with special emphasis on use of self-instruction units, received close examination at a two-day Workshop of Medical Education held at Wayne State University. The conference was sponsored by the Division of Educational Services and Research at the WSU School of Medicine. General chairman was Joseph W. Hess, M.D., far right, director of the Division of Educational Services and Research, WSU School of Medicine, sponsoring organization. Others pictured, from left: L. James Hallen, M.D., WSU Department of Medicine; Richard Anslow, M.D., Department of Medicine; Karl Kish, third year student from Howell, and V. K. Vaitkevicius, M.D., Director of Oncology at WSU.



MSU SPEECH and Hearing Clinician Lillian Richeson works with Kelly Pease in university clinic's new program for cerebral palsied preschoolers. Miss Richeson and an occupational therapist and four graduate students work under a senior staff member with Kelly in three-hour sessions four days a week. The program helps children understand the meanings of words, use words appropriately and grasp abstract concepts. The Michigan United Cerebral Palsy Association is a co-sponsor.



EDWARD HARDICK, Ph.D., gains confidence and attention of Sandra Bommer, 2, during a hearing test. The MSU Speech and Hearing Clinic is emphasizing work with two and three-year-old children with hearing handicaps in an effort to improve their language skills for learning. MSU has 150 graduate and undergraduate students majoring in speech and hearing.

MSU Speech, Hearing Clinic Serves Public, Trains Therapists

A WIDE VARIETY of sound equipment aids clinic researchers who see from 25 to 30 persons a week for diagnosis and 60 to 100 persons two to three times a week for rehabilitation. The Clinic also offers services to area hospitals, community hearing centers and schools. Herbert J. Oyer, Ph.D., standing, is director.



Kellogg Foundation Is A Pace Setter

The W. K. Kellogg Foundation, for educational or charitable purposes, recently issued its 1968 Annual Report describing many projects "to shape and reshape informational and institutional patterns to cope with the demands to change." Here are photos about three grants.



MSU AND SIX OTHER colleges receive Kellogg Foundation assistance to initiate and develop new medical schools to help increase the number of physicians. Above a MSU professor and medical student examine a patient.



THE ASSOCIATION OF American Medical Colleges Division of Operational Studies was established in 1959 by a Kellogg Foundation grant, which has been extended. AAMC personnel, shown above, collect facts about medical center management and conduct various educational programs to disseminate the information. The Division staff provides consultation to medical schools on budgeting, program cost analysis, student expenditures, etc.



THE KELLOGG FOUNDATION finances the MSU Detroit Project for a four-year program to provide Foundation-aided professional counseling to help Negro students from Detroit inner-city high schools to attend MSU. Of the first group of 70 students, 59 survived the first term. The personally-committed counselors meet regularly with the students.

See next page for prescribing informatio



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specifics in acute otitis media

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, the most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strains may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged action permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity, onycholysis and discoloration of the nails (rare). Kidney—rise in BUN apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

398-

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

now she can cope...

thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)



the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.



If you think the pink pill for U.R.I. symptoms is built for speed and endurance you're on the right track.

Here is a tablet that begins to relieve symptoms of upper respiratory infection quickly—a tablet that works for hours to make it easy for your patient to enjoy continuous relief.

Novahistine Singlet combines effective dosage of an antipyretic-analgesic with a vasoconstrictor-antihistamine formulation to relieve not only the congestion, but also the fever and the aches and pains that almost always accompany upper respiratory infections.

A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine®
Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW

The Medical Protective Company which insures approximately 80% of Michigan physicians, has new premium rates effective January 1, 1969 as follows. Bureau companies, which insure most other Michigan doctors, had similar increases effective Dec. 18, 1968.

New Malpractice Insurance Rates In Effect

BY RICHARD CAMPAU
MSMS DIRECTOR OF ECONOMIC RESEARCH

NEW RATES FOR MEDICAL PROTECTIVE POLICIES

Area I: Genesee, Oakland & Wayne Counties. Area II: Rest of State.

CLASS I: SPECIALIZING IN

Internal Medicine, Cardiovascular Diseases, Allergy, Neurology, Chest, Pediatrics, Pathology, General Practice (no Surgery or Anesthesia), Psychiatry (no shock therapy), Radiology or Dermatology (no X-ray therapy).

Limits	$10,000	$25,000	$ 50,000	$100,000	$200,000
	$30,000	$75,000	$150,000	$300,000	$600,000
Areas I & II	$67	$91	$103	$114	$140

CLASS II: SPECIALIZING IN

Psychiatry (including shock therapy), General Practice (Performing normal deliveries or assisting in Surgery).

Limits	$10,000	$25,000	$ 50,000	$100,000	$200,000
	$30,000	$75,000	$150,000	$300,000	$600,000
Areas I & II	$104	$141	$159	$176	$216

CLASS III. SPECIALIZING IN

General Practice (doing Surgery or Anesthesia), Proctology, Ophthalmology.

Limits	$10,000	$25,000	$ 50,000	$100,000	$200,000
	$30,000	$75,000	$150,000	$300,000	$600,000
Area I	$323	$437	$494	$546	$671
Area II	$243	$329	$372	$412	$506

CLASS IV: SPECIALIZING IN

Surgery, Urology, Thoracic Surgery, Cardiovascular Surgery, Colon and Rectal Surgery, Otolaryngology (excluding Plastic Surgery).

Limits	$10,000	$25,000	$ 50,000	$100,000	$200,000
	$30,000	$75,000	$150,000	$300,000	$600,000
Area I	$506	$685	$775	$857	$1053
Area II	$379	$513	$580	$642	$789

CLASS V: SPECIALIZING IN

Obstetrics and Gynecology, Anesthesiology, Orthopedic Surgery, Plastic Surgery, Neurological Surgery, Otolaryngology (including Plastic Surgery).

Limits	$10,000	$25,000	$ 50,000	$100,000	$200,000
	$30,000	$75,000	$150,000	$300,000	$600,000
Area I	$757	$1025	$1158	$1282	$1574
Area II	$506	$685	$775	$857	$1053

INGRAM'S SERVICE DEPARTMENT

ALL FACTORY TRAINED MEN

We service Medical Equipment, Electrocardiographs, Basal Metabalors, Sterilizers, Autoclaves, Diathermy Outfits, Cutting Units, Ultra Violet Lamps, Hydro Therapy Units, Laboratory Equipment. ALL BURDICK, LIEBEL FLARSHEIM AND RITTER EQUIPMENT.

If you have any Service problems, please call us at TE 2-4444, ask for the SERVICE DEPARTMENT and we will gladly help in any way we can.

THE G. A. INGRAM COMPANY

4444 Woodward Avenue TEmple 2-4444 Detroit, Michigan 48201

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

DETROIT OFFICE: G. A. Triplett, R. K. Wind and J. K. Galloway, Representatives
27200 Lahser Road, Southfield 48075 Telephone: (Area Code 313) ELgin 3-4348 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative
422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477

Questions and Answers:

About the Progress and Programs Of the Michigan Association for Regional Medical Programs

(Editor's note: The following article lists a series of questions raised by the MSMS Committee on Postgraduate Medical Education about the Michigan Association for Regional Medical Programs and the answers provided by Albert E. Heustis, M.D., M.P.H., Director of MARMP.)

QUESTION

What grants have been approved, for how much, and to whom and for what purposes?

ANSWER

This question refers to the federal funds allocated for use prior to June 30, 1968. MARMP received $1,294,449 in June 1967. These funds were allocated as follows:

MARMP Central Staff	$ 161,781
Mich. Dept. of Public Health	189,112
Michigan State University	188,564
University of Michigan	356,715
Wayne State University	202,846
Unbudgeted	195,431
	$1,294,449

The initial grant was to develop a planning capability at the above listed institutions. During this period institutional staffs have developed proposals for submission under the RMP and have contributed to the development of a regional plan for the Michigan Region. The Michigan Department of Public Health did not utilize their funds for a planning staff. With MARMP federal approval, they partially supported Project ECHO.

QUESTION

What percentage of the first federal grant to MARMP has been allocated, and how much is being spent for the operation of MARMP?

ANSWER

Eighty-five percent of the original appropriation was allocated by MARMP. However, none of the recipients fully utilized appropriated funds. Approximately 49% of the $1,294,449 was spent. The remaining authorization (51%) automatically reverted back to the federal RMP program.

QUESTION

What is the status of a second-year request to the federal government for planning funds?

ANSWER

MARMP was awarded $1,862,567 for the 12-month period commencing July 1, 1968. These funds were allocated as follows:

MARMP Central Staff	$ 279,235
Michigan Department of Health	357,206
Michigan Heart Association	94,277
Michigan State University	281,994
University of Michigan	586,105
Wayne State University	162,486
Zieger/Botsford Hospital	101,354
	$1,862,657

Readers might be interested in programs presently being processed by MARMP. Providing these projects are found acceptable by both our Regional Advisory Group and the Federal Division of Regional Medical Programs, we could anticipate funding during June, 1969. A listing of the programs under review (and the sponsor) is as follows:

Michigan Heart Association: (1) Establishing and Evaluating C.P.R.*; (2) Training Programs to Develop Faculty for Rescue Groups and Para Medical Schools

Michigan State University: Central Michigan Comprehensive Stroke Program

Wayne State University: (1) Demonstration Unit for the Education of Health Personnel in Pulmonary Diseases; (2) An Experimental Continuing Education Program for Small Inner City Hospitals; (3) Rehabilitation Nursing Training and Utilization; (4) Augmented Library Service; (5) Development of a Comprehensive Attack on the Problems of Stroke in Michigan

Hackley Hospital, Muskegon: Nuclear Medical Technologist Training

Detroit Osteopathic Hospital: Stroke Demonstration Unit

Mercy Hospital, Benton Harbor: Development of a Cardiovascular Center

Zieger/Botsford Hospital: Continuation of Continuing Education Planning Grant

QUESTION

Have any requests been made for operational funds to test early plans?

ANSWER

The "phase 2" funds are to support the following MARMP approved programs:

a. A hypertension physician-education project at Sparrow Hospital (sponsored by Michigan State University).
b. A professional education program (sponsored by the Michigan Heart Association).
c. A planning study of nursing postgraduate educational requirements (sponsored by the University of Michigan).
d. A drug information program (to be piloted at the University of Michigan and one outstate location yet to be selected) to answer questions related to drug usage side effects (sponsored by the University of Michigan).
e. A planning study concerning possible usage of non-professional staff to accomplish routine health care in a Michigan community (sponsored by the University of Michigan).
f. A planning grant to help develop post graduate dental education (sponsored by the University of Michigan).
g. A survey of physician attitudes to determine how a physician learns and how we may structure professional educational programs to facilitate learning (sponsored by the University of Michigan).
h. A survey of professional knowledge to determine needed areas for educational offerings (sponsored by Zieger/Botsford Hospitals).

QUESTION

What is the MARMP process for reviewing applications and who serves on the screening committees?

ANSWER

a. Central staff reviews the formal application from the viewpoint of appropriateness to Regional Medical Programs, legal requirements, cooperative arrangements and other general requirements.
b. A technical review committee, appointed by central staff with the advice of chairmen of appropriate Professional Advisory Councils and Task Forces and other knowledgeable individuals, conduct a site visit to meet with the project applicant. This committee considers the technical and scientific validity and value of the project.
c. The Board of Directors of MARMP receives and considers the reports of central staff, the technical review committee and a special report by a designated Board member. They forward their recommendations to the Regional Advisory Group.
d. The Regional Advisory Group receives the recommendations of the Board of Directors and considers the project application in terms of whether it fits into the MARMP Regional Plan and whether it will make a significant contribution to improved patient care in heart disease, cancer, stroke or related diseases. Their decisions can be either full approval for further submission to Washington, full rejection, or a request for the applicant to rewrite or answer further questions.
e. If the application is approved, it is then sent to the Federal RMP for processing at that level.

QUESTION

When will MARMP employ a communications expert to make it possible for MARMP to carry out a more extensive informational program?

ANSWER

MARMP has not included funding for a communications expert on the central staff budget. However, we realize the importance of keeping the professional community abreast with the status of our organization. By these questions, it is evident that we have failed to convey our program to interested parties. We will attempt closer coordination with MSMS and other professional organizations having journals and periodic newsletters. We anticipate that we may add a communications expert to our staff at some future date.

QUESTION

What proposals has MARMP approved that specifically involve or concern the Upper Peninsula?

ANSWER

In the interim we have attempted to encourage involvement by the Upper Peninsula physicians. As recently as December 13, 1968, Dr. Larocque, our associate director, returned from a two-week get-acquainted-tour whereby she attempted to answer their questions and provide an insight into MARMP's progress.

QUESTION

Why do some of the requesting groups complain about delays in MARMP action on proposals?

ANSWER

While it would be difficult to determine why "some groups" complain about the delays in MARMP's action on proposals, we can enumerate two basic problems. (1) Due to the complicated federal funding procedures, extensive federal review processes, and review requirements delegated to our organization, it is practically impossible to obtain funding in less than 6 months from the time an applicant submits a project to MARMP. Enthusiasm is further lost by the delay between an applicant's conception of an idea and the actual application submission to us. Not only do most institutions have internal review processes,

(Continued on Page 273)



Hot
under
the collar...

high under
the cuff.

Sometimes
he forgets he has hypertension, gets hot
under the collar...high under the cuff.

For such
patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6392

but the applicant must involve the "full array" of interested health professionals in the development of "his" idea. While these "checks and balances" take time, they are really what this program is all about. The government desires to insure that the health community is truly involved in the establishment of objectives and supports the requested program. (2) MARMP has attempted to develop a regional plan and fund projects all at the same time. While these actions are not compatible, it did not seem wise to sit on our hands while we were building our bridges and developing our planning structure. MARMP has attempted to move slowly. We desire to improve patient care, but we do not want to recklessly approve programs that may in the long run not be in the best interest of our region. With the many capable professionals in Michigan, we could easily have swamped Washington with many good projects. However, the federal dollars are not endless. We could have so committed ourselves to "good programs" that better programs would have been left high and dry.

Presently, we are holding all proposals in abeyance pending approval of a revised state plan. Our Task Forces are submitting reports, a special study committee is consolidating findings, and we are holding a special Regional Advisory Group meeting on October 4 to, hopefully, approve the finalized regional plan.

QUESTION

How are physicians practicing across the state now involved in MARMP project planning?

ANSWER

Physicians practicing across the state are involved in all levels of MARMP, including project planning.

There are 5 private practicing on the Regional Advisory Group, 3 on the Board of Directors, 7 on the PAC on Heart Disease, 9 on the PAC on Cancer, 5 on the PAC on Stroke, 1 on the Task Force on Incidence and Prevalence, 3 on the Task Force on Continuing Education, 1 on the Task Force on Compatibility of Educational Media, and 2 on the Task Force on Methods and Evaluation.

All of these physicians are helping to develop the MARMP Regional Plan. Local physicians have helped develop several projects soon to be funded by MARMP:

a. A hypertension education center in Lansing:
b. A project concerned with continuing education planned by Zieger/Botsford Hospitals.
c. Continuing education for nurses and physicians in coronary care units.

More physicians have been involved in projects now under review and discussions have been held with some physicians wishing to submit projects in the future.

QUESTION

How are physicians in the field helping to plan regional requests for MARMP funds?

ANSWER

See above answer also — Practicing physicians are usually asked to serve on the technical review committees and, of course, 5 private practicing sit on the Regional Advisory Group which has the final authority for submission of a regional request to Washington.

QUESTION

How much detailed information does the Council of MSMS have about the operations of MARMP?

ANSWER

Don Marshall, M.D., a Councilor of MSMS, serves as the Vice-President of MARMP. Dr. Heustis also keeps communications open between MARMP and Mr. Hugh Brenneman, executive secretary of MSMS.

CPHA ISSUES REPORT ON HOSPITAL STAYS

FROM THE AMA

Although teaching hospitals have more complicated cases than do nonteaching hospitals, the longer average stay in teaching hospitals is due more to the "teaching effect" than to the patient mix, according to the Commission on Professional and Hospital Activities, Ann Arbor. Findings resulting from a 1966 study of U.S. short-term general hospitals by the Commission were published in *PAS Reporter.*

The study involving 209 teaching hospitals and 326 nonteaching hospitals found that patients' average stays of 7.8 days in teaching hospitals and 6.8 days in nonteaching hospitals. These lengths of stay were converted for differences in complexity of cases (patient mix) to "expected" average stay — the average stay created by assuming that each patient is an average patient in his respective class. There were 3,660 classes of cases similar in complexity as defined by:

a. Cause of hospitalization
b. Presence or absence of complicating conditions
c. Surgical vs. medical management
d. Age

Patient mix differences account for only 0.3 days out of the 1.0 days longer average stay in the teaching hospitals, the study shows. The remainder, 0.7 days, is due to the "teaching effect" which slows the delivery of care.

So he'll breathe easier:

relieve anxiety while you relieve pain.

Relief of pain is usually a major goal in traumatic conditions. But often of importance, too, is alleviation of anxiety and tension that may heighten patient discomfort.

Single-prescription, non-narcotic Equagesic may effectively relieve pain. *And* ease anxiety and tension.

TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin)

Wyeth®

IN BRIEF.

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

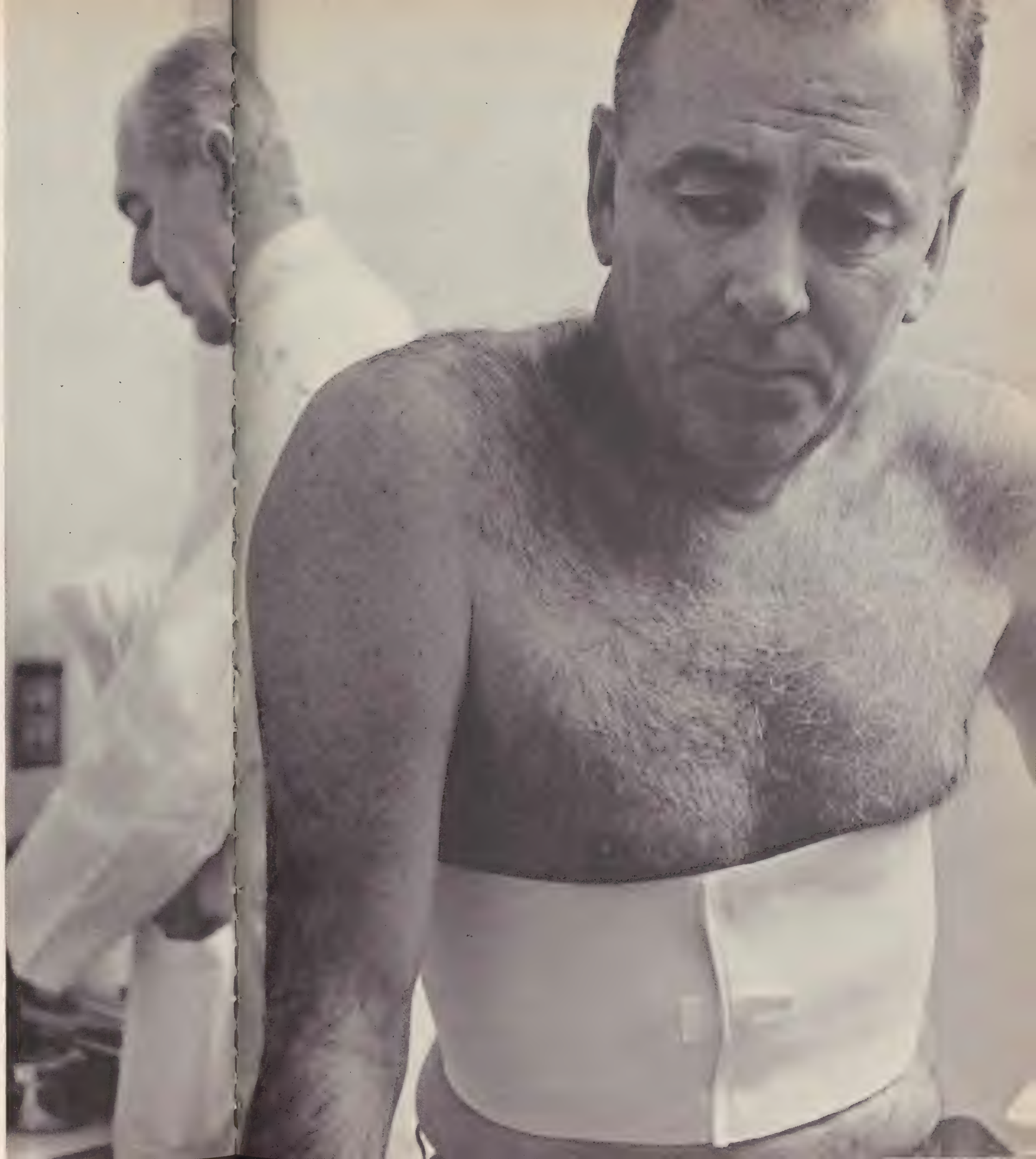
Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.



MAP To Mark 10th Year At Annual Congress

The Michigan Association of the Professions will celebrate its 10th anniversary at its annual Congress of the Professions April 11 and 12 at the Jack Tar Hotel, Lansing. Other meetings of the American Association of the Professions will be incorporated in the Congress.

The program is now being completed.

Heart Association Sessions Schedule Six Speakers

Six nationally-known researchers will be the featured speakers at the 20th anniversary Scientific Sessions of the Michigan Heart Association, scheduled April 11 and 12 at the Sheraton-Cadillac Hotel in Detroit.

Leading the six is James K. Alexander, M.D., director, Cardiovascular Research Laboratory, Baylor University.

The others are Thomas Killip, III, M.D., professor, Cornell University Medical College and director of Coronary Care Units at New York Hospital; Leonard S. Dreifus, M.D., director of Electrophysiology and Electrocardiographic Units, Hahneman Medical College, Philadelphia; Albert A. Kattus, Jr., M.D., chief, Division of Cardiology, Vanderbilt University School of Medicine; R. Bruce Logue, M.D., cardiologist at Emory University Hospital and a former vice president and member of the board of trustees of the American Heart Association; Henry N. Wagner, Jr., M.D., professor of radiology and radiological science, Johns Hopkins University, vice president of the Society of Nuclear Medicine and consultant to the Oak Ridge National Laboratory.

Doctor Logue will deliver the Frank N. Wilson-Gordon O. Myers Lecture at the conference, which will have a cardiac therapy theme. The speakers will discuss coronary care units Friday afternoon, coronary artery disease Saturday morning and thromboembolism Saturday afternoon.

DOCTOR SWAN APPOINTED TO HEW ADVISORY GROUP

Lionel F. Swan, M.D., of Detroit, has been appointed to the Health Insurance Advisory Council to the secretary of HEW.

Doctor Swan is immediate past president of the AMA. The council is made up of representatives of associations and organizations in the fields of medicine and experts in the financing of health care who will advise the HEW secretary on matters of policy in the Medicare Program.

MAGP Post-Grad Clinic Includes Michigan Doctors

Among the speakers and exhibitors of the 23rd annual Postgraduate Clinic March 12-13 of the Michigan Academy of General Practice will be several Michigan doctors.

MSMS President James J. Lightbody, M.D., will preside at the second session on Wednesday, March 12, which will include a panel discussion of "O. B. Complications."

On the panel will be Tommy Evans, M.D., professor of obstetrics and gynecology at Wayne State University School of Medicine. Henry Krystal, M.D., Detroit, will lead a "wet clinic" discussion of "Frequently-Encountered Mental Disorders," one of a series of instruction-in-depth sessions Thursday afternoon, March 13.

Among the 32 scientific exhibits scheduled will be "Present-Day Management of Fistula in Ano and Perianal Infections" — T. C. Arminski, M.D., and Don W. McLean, M.D., both of Detroit; "Abdominal Aortic Aneurysmectomy: What Can It Accomplish?" — D. Emerick Szilagyi, M.D., Roger F. Smith, M.D., Joseph P. Elliott, Jr., M.D., Frederick W. Sherrin, M.D., all of Henry Ford Hospital; "Xeroradiography of the Breast" — John N. Wolfe, M.D., Hutzel Hospital, Detroit; "Michigan Health Council M.D. Placement Service" — John A. Doherty, Marceline Lyons, Michigan Health Council, Lansing; "Adequate Medical Care for the Aged" — F. P. Rhoades, M.D., Detroit; "Frequent Plastic Surgical Proglems" — William A. Lange, M.D., Detroit; "Michigan Heart Association's Continuing Education for Physicians" — John Bielawski, M.D., Detroit, and "Cancer of the Skin: The Most Common and Most Preventable Cancer" — George T. Britton, M.D., and Ralph C. Pickett, American Cancer Society, Michigan Division, Inc., Lansing.



ANCILLARY

HOSPITAL ASSOCIATION BACKS MSU PLAN

The Michigan Hospital Association has gone on record as urging the Governor of the State of Michigan and the legislature to proceed with the expansion of the two-year College of Human Medicine at Michigan State University to a complete college of medicine granting a doctor of medicine degree.

The hospital association board of trustees also strongly urged the state legislature to make such appropriations as might be necessary to accomplish this objective.

The state hospital association joins with MSMS in forwarding formal MSU resolutions to the governor and the legislature.

During late 1968, MSMS held a series of medical manpower conferences at Detroit, Battle Creek, Grand Rapids, Saginaw and Bloomfield Hills with hospital administrators among the guests.

BIOMED SCIENCES SYMPOSIUM THEME "IMAGERY IN SCIENCE"

"Imagery in Science" is the theme of the 7th annual National ISA Biomedical Sciences Instrumentation Symposium to be held May 19-21 in Ann Arbor.

The Instrument Society of America's Biomedical Sciences Division and the University of Michigan will co-sponsor the symposium, which coincides with the 100th anniversary celebration of the University Hospital. Chairman is Ernest E. Sellers, U-M Institute of Science and Technology.

An exhibit of biomedical instrumentation products will be held concurrently with the symposium.

Technical sessions will focus on recent developments in the following image-producing displays and techniques: optical image processing; radionuclide, X-ray and fluoroscopic imaging; fiber optics applications; computer displays; holography; vector cardiography; neutron radiography; xerography; thermography; sonography; medical television and teaching aids.

Advance programs and registration forms may be obtained by writing to the Instrument Society of America, Meetings Assistant, 530 William Penn Place, Pittsburgh 15219.

ROSELAWN MANOR

A Convalescent - Retirement Residence for Senior Citizens

Offering complete convalescent care with a complete staff of nurses and attendant personnel for every need in 220 units.

707 ARMSTRONG RD., LANSING, MICH. 48910
Phone 393-5680



When you take an electrocardiogram you expect dependable, trouble-free performance, even under difficult conditions. You want to be sure your patient's tracing is diagnostically accurate; clear in detail. The Burdick EK 4 has the frequency response, the reliability and the serviceability you want and should have. If your present ECG does not provide the significant improvements that have been designed into cardiograph equipment in recent years, you may not be providing the service you want for your patients. You need the best, and this is what you get with the Burdick EK 4. It's what Burdick stands for. See your Burdick dealer for complete details.

THE BURDICK CORPORATION
MILTON, WISCONSIN 53563

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit, Michigan 48201
Telephone: TEmple 2-4444



BRIGHTON HOSPITAL

A non-profit foundation

FOR ALCOHOLISM

Member, Michigan Hospital Association, American Hospital Association

A facility designed to rehabilitate and aid the compulsive drinker in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board.

12851 East Grand River
One block south of I-96 at Kensington Rd. Exit four miles east of U. S. 23
Brighton, Michigan
ACademy 7-1211

(A 16-m.m. sound color film on Brighton Hospital is available for free loan to qualified groups.)





Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

A·H·ROBINS

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

MICHIGAN'S MATERNAL MORTALITY

Michigan's 1967 maternal mortality rate of 3.0 per 10,000 livebirths is the lowest on record, according to Bernard H. Siebers, M.D., chief of the Bureau of Maternal and Child Health, Michigan Department of Public Health.

The figures behind his conclusion break down as follows:

SUMMARY
MICHIGAN MATERNAL MORTALITY STUDY
1967

DIRECT OBSTETRIC DEATHS			
Infection		15	
Post-abortal	9		(9)
Post-partum	6		
Hemorrhage		12	
Ectopic	4		
Hydatid Mole	1		
Post-partum	7		
Vascular ACCIDENTS		11	
Venous embolism	6		
Air Embolism	3		(3)
Amniotic fluid	2		
Anesthesia		6	
Toxemia		2	
Other		2	
		48	(12) attributed to abortions
INDIRECT OBSTETRIC DEATHS		9	
NON-RELATED DEATHS		6	
TOTAL		63	

Approximate Maternal Mortality Rate — 3.0 per 10,000 livebirths

EYE CARE COMMITTEE'S ACTIVITIES RECEIVE **PR DOCTOR** MENTION

The activities of the MSMS Eye Care Committee are described in the current issue of the American Medical Association *PR Doctor* magazine.

The publication is sent to leaders of county and state medical societies to serve as a source of ideas.

The story tells how the MSMS Committee is trying to locate deaf-blind children in order to obtain for them special care, training and education.

PATHOLOGISTS TO MEET MAY 10

Speakers at the February meeting of the Michigan Society of Pathologists at Henry Ford Hospital, Detroit, were two members, Ronald Nishiyama, M.D., and John Rebuck, M.D.

They discussed several important and difficult cases of blood disorders collected from their own material and that of other society members. Doctor Nishiyama is associate professor of pathology at the University of Michigan and Doctor Rebuck is with the Department of Pathology at Henry Ford Hospital.

The group's next meeting will be at 1:30 p.m., May 10, at Mt. Sinai Hospital, Detroit, when Jesse E. Edwards, M.D., of the Mayo Clinic at Rochester, Minn., will talk about "Disorders of the Cardiovascular System."

in the treatment of
IMPOTENCE
Android®
(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY
ANDROID — GOOD TO EXCELLENT 75%
PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android
Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid ..... 50 mg
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY
Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid ..... 50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY
Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid ..... 50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

REFER TO PDR

also available with ESTROGEN

Android-E
Each Tablet Contains:
Methyl Testosterone ..... 2.5 mg.
Ethinyl Estradiol ..... 0.02 mg.
Thyroid Ext. (1/6 gr.) ..... 10 mg.
Thiamine Hydrochloride .... 10 mg.
Glutamic Acid ..... 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Folders Explain Use of Chemoprophylaxis For TB Prevention

A desk reference folder providing information and appealing for cooperation has been sent by the Michigan Thoracic Society to many Michigan physicians in an educational effort to increase use of the isoniazid treatment to prevent active tuberculosis.

"Emphasis in the control of tuberculosis today is being placed on the use of chemoprophylaxis to prevent TB, stresses Robert A. Green, M.D., Ann Arbor, president of the Michigan Thoracic Society, medical section of the Michigan Tuberculosis and Respiratory Disease Association.

The desk reference folder, "Chemoprophylaxis for the Prevention of Clinical Tuberculosis," contains information about the results of extensive United States Public Health Service studies that showed the effectiveness of isoniazid treatment. Also included are recommendations for dosage and priority groups for chemoprophylaxis.

The recommendations are made by the Michigan Thoracic Society, the Michigan Department of Public Health and the Michigan Tuberculosis and Respiratory Disease Association, based on the recommendations of the national organizations.

Priority groups recommended for chemoprophylaxis, Doctor Green said, include persons with inactive tuberculosis who have not had adequate chemotherapy and certain tuberculosis reactors. He said the American Thoracic Society recommends that ideally, all positive reactors should receive chemoprophylaxis, and therefore, private physicians can have a significant impact on the prevention of clinical tuberculosis. Routine tuberculin tests of patients followed by X-rays and chemoprophylaxis for reactors would help protect patients, an important high TB risk group in the community.

"The private physician is also in a key position in regard to recommending chemoprophylaxis for reactors in special clinical situations, such as unstable diabetes, pregnancy and patients on steroid treatment," Doctor Green declares.

The MTRDA has sent a special mailing of the desk reference folder to doctors in the 73 counties that it serves directly.

Interested physicians who did not receive the folder or who want extra copies may write to the Michigan Tuberculosis and Respiratory Disease Association, 403 Seymour, Lansing 48914.

POISON PREVENTION PANELS SET MARCH 18 AT WAYNE

Two panels including Michigan doctors are scheduled March 18 at McGregor Conference Center, Wayne State University, for a poison prevention program jointly sponsored by WSU and the U. S. Food and Drug Administration.

MSMS Executive Director Hugh W. Brenneman will chair one panel which will discuss the hazards of misused common drugs. The other, led by John A. Doherty, executive secretary, Michigan Health Council, will study accidental poisonings caused by the thoughtless use and storage of common chemical products used in the house, garden and garage.

Both panels will be open to the public and industry and are part of the WSU-USDA program, "Poison Is No Picnic," planned in conjunction with National Poison Prevention Week.

On the Brenneman panel will be Frederick J. Margolis, M.D., Kalamazoo pediatrician and director, audio visual unit, WSU School of Medicine; Raymond Semplici, drug inspector, U. S. Food and Drug Administration, Detroit District; L. M. Lueck, Ph.D., vice president, quality control and government regulations, Parke-Davis and Company; Eugene Dembicki, R.Ph., chief, pharmacy services, Lafayette Clinic, and James Richards, Ph.D., associate professor of pharmacy, University of Michigan, panel recorder.

The Doherty panel will be comprised of Norbert Reinstein, United Community Services; Regine Aronow, M.D., director, Poison Control Center, Children's Hospital of Michigan; Anthony C. Celeste, chief, laboratory branch, U. S. Food and Drug Administration, Detroit district; Cathryn Kurtagh, R.N., Visiting Nurses Association; and William Fredericks, Sc.D., director, Bureau of Industrial Hygiene, Detroit Department of Health.

E. Jane Crawford, Benton Harbor, New State Industrial Nurses Head

E. Jane Crawford, R.N., of the Voice of Music Corporation in Benton Harbor, is new president of the Michigan State Association of Industrial Nurses, Inc. She succeeds Alice Levantrosser, R.N., of the Michigan Bell Telephone Co., Detroit.

Other 1969 officers, designated at the industrial nurses' 21st annual meeting Jan. 17-18 in Detroit, include Mary Seaver, R.N., Trenton, first vice president; Alice Eldred, R.N., Flint, second vice president; Lucile Mott, R.N., Saginaw, corresponding secretary; Wilma Michael, R.N., Midland, membership secretary; Jane Crippen, R.N., Detroit, recording secretary, and Mary Abernathy, R.N., Flint, treasurer.

On the board are Janice Winchell, R.N., Kalamazoo; Eleanor Rasak, R.N., Pontiac; Joyce Winters, R.N., Lansing, and Leona Kaiser, R.N., Saginaw.

The association scheduled its spring conference May 17-18 in Albion and will hold its fall conference in October in Lansing.

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

- Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.
- Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.
- Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop



THE BETTMAN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

ANTISECRETORY SEDATIVE

Antrocol®

Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to slow, even absorption.

Each Antrocol tablet or capsule contains 0.324 mg. of atropine sulfate, which is twenty-four thousandths of a milligram more than the smallest effective dose specified in U.S.P., Vol. 17. This slight increase in the smallest effective dose of the antisecretory factor (atropine) is all the average patient can tolerate without discomfort.

One Antrocol tablet or capsule taken three times daily lessens emotional stress and maintains a gastric function that is not conducive to the development of peptic ulcer.

Antrocol is also useful in the treatment of peptic ulcer. Dosage up to 8 tablets or capsules per day to obtain the desired antisecretory titer. When ulcer has healed, one Antrocol tablet or capsule morning and evening gives protection against recurrence.

Each tablet or capsule contains:

Atropine Sulfate	0.324 mg.
Phenobarbital (may be habit forming)	16 mg.
Bensulfoid, see white section P.D.R.	65 mg.

Side-effects: Toxic levels of atropine may produce flushing, dry mouth, blurred vision, tachycardia, or urinary retention. Precautions: Do not use in glaucoma. Use cautiously in prostatic hypertrophy.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Antrocol®

ANTISECRETORY SEDATIVE



NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Martin L. Beard, M.D., 6606 N. Saginaw Street, Flint 48505

Paul C. Colligan, M.D., 960 Agard Street, Benton Harbor 49022

James H. Grove, M.D., 102 N. Fourth Street, Niles 49120

Burton Jaffe, M.D., University Medical Center, Ann Arbor 48104

W. John Kenfield, M.D. (From Associate) P.O. Box 6, St. Joseph 49085

Bruce F. Knoll, M.D., 710 S. Brown Street, Jackson 49203

Richard W. Lingenfelter, M.D., 28 South Prospect Street, Ypsilanti 48197

Diana Little, M.D., 317 South State Street, Ann Arbor 48104

Jarlath Quinn, M.D., 1116 Ann Arbor Street, Flint 48503

Serafin L. Samson, M.D., 160 Park Street, Adrian 49221

Orhan A. Tugrul, M.D., 1767 North Lapeer Road, Lapeer 48446

L. William Vergith, M.D., 2765 Flushing Road, Flint 48504

Robert L. Weeldreyer, M.D., 121 West 24th Street, Holland 49423

C. R. Yang, M.D., 560 Linn Street, Allegan 49010

William K. Miles, M.D., University Hospital, Ann Arbor 48104

Winnifred E. Storey, M.D., Box A, Ypsilanti 48197

Christopher A. Leuz, III, M.D., 923 Maybelle Street, N.E., Grand Rapids 49503

Willard S. Stawski, M.D., 816 Pinecrest Ave., S.E., Grand Rapids 49506

Charles H. Sander, M.D., Dept. of Pathology, Michigan State Univ., East Lansing 48823

Smail B. Sendi, M.D., Pontiac State Hosp., 140 Elizabeth Lake Road, Pontiac 48053

William J. Sinclair, M.D., 1005 Abbott Road, East Lansing 48823

Scott N. Swisher, Jr., M.D., Dept. of Medicine, Mich. State Univ., East Lansing 48823

James A. Twing, M.D., 785 North Lapeer Road, Lake Orion 48053

Peter Ways, M.D., Dept. of Medicine, Mich. State Univ., East Lansing 48823

Marvin S. Weckstein, M.D., 28290 Tavistock Trail, Southfield 48075

William B. Weil, Jr., M.D., Dept. of Human Develop., Mich. State Univ., East Lansing 48823

Glen H. Douglass, M.D., 1324 S. Park, Kalamazoo 49001

W. K. Lehmann, M.D., Alpena General Hospital, Alpena 49707

Alfred E. Neuffer, M.D., 5384 Territorial Road, Grand Blanc 48439

Soo H. Pai, M.D., Borgess Hospital, 1521 Gull Road, Kalamazoo 49001

Katherine A. Shaffer, M.D., Pontiac General Hosp., Pontiac 48053

Daniel E. McGunegle, M.D., Pontiac Gen. Hosp., Pontiac 48053

John Halick, M.D., Pontiac State Hospital, Pontiac 48053

Telesford E. Garcia, M.D., Pontiac General Hospital, Pontiac 48053

Luis Posada, M.D., 1322 E. Michigan Ave. #214, Lansing 48912

Paul A. Scholtens, M.D., Alpena General Hosp., Alpena 49707

Howard R. Ackerman, Jr., M.D., 909 Woodward Ave. #104, Pontiac 48053

Sandra Daugherty, M.D., Dept. of Med., MSU, East Lansing 48823

Krikor Ficici, M.D., 602 Burtman Drive, Troy 48084

Arthur F. Kohrman, M.D., Dept. of Human Develop., Mich. State Univ., East Lansing 48823

Peter P. Medrano, M.D., 32310 Schoolcraft, Livonia 48154

Frank Pacoletti, M.D., Sparrow Hospital, Lansing 48902

David J. Rothwell, M.D., Pontiac General Hospital, 461 West Huron St., Pontiac 48053

FIVE ST. CLAIR COUNTY PHYSICIANS GIVEN AWARDS

The St. Clair County Medical Society has presented its Distinguished Medical Society Award to five Port Huron doctors. They are John R. Ware, M.D., local physician for 38 years of service; Marion E. Bovee, M.D., for 50 years; D. W. Patterson, M.D., for 53 years; G. Douglas Treadgold, M.D., for 48 years, and John C. S. Battley, M.D., for 40 years.

AN IMPORTANT MESSAGE ON SPUTUM CYTOLOGY

Sputum Cytology—practical and economical as a routine diagnostic aid for the detection of lung cancer to be used in conjunction with other diagnostic techniques (such as roentgenology and bronchoscopy) in industry, hospitals, community health centers, and private practice.



AN AID TO THE MEDICAL COMMUNITY: Sputum cytologic screening is an aid in lung cancer detection when used with professional judgment as part of the diagnostic workup of the patient.

Pulmonary exfoliative cytology is a useful diagnostic aid when used in conjunction with other diagnostic techniques in early lung cancer detection; however, problems in sputum collection, difficulties in preparation, and expenses involved have made it impractical for routine screening. As a consequence, it has not been used to the fullest in private, industrial, and public health programs. The CYTEC® System of Sputum Cytology helps overcome most of these problems.

The CYTEC System is sputum cytology with rapidity

Developed by Nuclear Research Associates, Inc., the CYTEC System provides reliable collection, preservation, separation, and concentration of cells as well as automated staining, all with accuracy, uniformity, speed, and simplicity.

This System has been tested for the last few years in industrial and commercial pilot investigation programs as well as in numerous major hospitals.

CYTEC is simple, convenient and easy to use

The CYTEC System provides a sputum collection kit containing a plastic test tube with a built-in funnel which facilitates the collection of early-morning "deep cough" specimens. A tight-fitting cap creates a leak-proof receptacle containing a preservative/fixative which eliminates the need for refrigeration.

The patient simply collects the sputum produced by early-morning "deep coughs," on four separate days, closes the test tube and returns it to his physician, medical director at his place of employment, or public health officer who can then send it in the self-contained mailer directly to our Ca Detection Laboratories for analysis. Reports will be returned only to the designated physician. Photomicrographs showing morphologic cellular changes, if present, accompany the physician's report.

CYTEC can be obtained only through the medical community

CYTEC is being offered *only* to practicing physicians including medical directors of industrial, community, and public health programs. It is being offered as a diagnostic aid to be used in conjunction with other techniques. CYTEC screening results serve as indicators for possible further workup.

A few words about Nuclear Research Associates, Inc., and its Ca Detection Laboratories

Nuclear Research Associates, Inc. is an interdisciplinary organization of physicians, physicists, biologists, chemists, and engineers working in the physical, biological, and medical sciences. The Ca Detection Laboratories represents a portion of Nuclear's recently established biomedical division and is devoted to research and technology in the cancer detection field. CYTEC is the first development to be offered to the medical community by the biomedical division. Others are on their way.

Professional information available on request.

Ca Detection Laboratories
12 Nevada Drive
New Hyde Park, N.Y. 11040



Midwest Distributor:
G. A. Ingram Co.
Litton Medical Products, Inc.
4444 Woodward Avenue
Detroit, Michigan 48201
Phone (313) 832-4444

CYTEC® is a registered trademark of Nuclear Research Associates, Inc.

FOLLOWUP ON DECEMBER ARTICLE:

Pharmacy Executive, Editor Exchange Views on Professional Teamwork

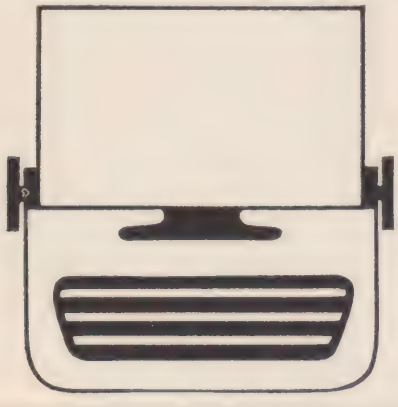
Dear Doctor Moses:

I am writing in reply to your editorial comments which appeared in conjunction with my annual report published in the *Michigan Pharmacist* (August issue) which you reprinted in the December issue of *Michigan Medicine*.

No less a noted medical educator than Dean William Hubbard has stated "The pharmacist is either the most over-educated or under-utilized person in society."

The views expressed in my annual report to the pharmacists of Michigan were not idle thoughts, but were arrived at after considerable thought and discussion with physicians and others involved in health planning and health care delivery.

The four points which you singled out of my report relative to the pharmacist's role in drug therapy suggests that you perhaps question the pharmacist's ability and/or responsibility in this important area of health care services. Let me assure you that I believe that the pharmacist's knowledge of drug therapy, if utilized, will undoubtedly occur in consultation with the physician. It is only felt that his delivery of service in this area can be enhanced by utilizing the medication expertise of the pharmacist. Other articles in the same December issue of *Michigan Medicine* comment on the medical manpower shortage and the use of non-physicians in performing certain heretofore exclusive medical functions. Why, then, not recognize those areas where the pharmacist, a valued member of the health team, can relieve the physician of time-consuming functions.



EDITORIAL VIEWS

An article appeared in the *New England Journal of Medicine* (June 22, 1967) authored by Doctor Ward Darley in which he states that "the pharmacist's future – quantitatively as well as qualitatively – may depend on his willingness and initiative in assuming larger challenges and responsibilities and on his ability to become a meaningful member of the comprehensive medical care team. I believe that exposing all pharmacy students to patients will better prepare them now and for the future role as members of the health team. Institutionalized and community patients will look to them for advice on drugs and their uses."

At an October 1968 Conference at the University of Michigan College of Pharmacy, Michael Papo, M.D., from Chelsea, Michigan, spoke on the subject of the pharmacist's role in medication. He made reference to the fact that the pharmacist should assume the role of a therapy advisor to the physician, he (the pharmacist) should be more involved in drug selection.

At the University of Michigan Annual Pharmacy Lectures in 1967, James Goddard, M.D., then U.S. Food & Drug Commissioner, stated "I strongly believe that the modern practice of medicine demands greater utilization of the knowledge and skills which only the pharmacist can offer. . . . There is a compelling logic for bringing the pharmacist out of the drug dispensary so that he may serve beside the physician as a Therapeutic Advisor."

Through this consulting role with the physician, as suggested by Drs. Papo, Darley and Goddard, the pharmacist is fulfilling a vital responsibility in recommending the medication regimen of the patient.

Relative to the selection of the specific brand of drug, who is better qualified than the pharmacist to make this determination? Many physicians constantly rely on the pharmacist for making this decision. Pharmacists are well qualified to determine which brand of phenobarbital, thyroid, penicillin, prednisone, reserpine, etc., can be dispensed to the patient most economically without sacrificing quality.

You infer that my four statements (or possibly the entire report) perhaps will "affect the relationship (between pharmacy and medicine) based on years of progress together." In reply to this, I could only hope that it *would* affect our relationship. I would hope that it would result in greater mutual respect for each other's health care respon-

sibilities and an even closer professional liaison than has existed heretofore.

Medicine appears to be recognizing the urgent need to utilize other health professionals for those services which they are educated for and qualified to deliver. Recent legislation and numerous Medical Society reports give evidence to this trend. Hopefully, the pharmacist with his five or six year education can fulfill a more meaningful role in health care delivery. Certainly, utilization of his medication knowledge can be helpful to the physician, possibly freeing him to devote more time to diagnosis, and other medical functions which only the doctor can perform. The health manpower shortage is of great concern to all of us. And of equal concern, is the most effective utilization of the health professionals' time. Together, I believe we can find the solutions to these problems.

In conclusion, let me assure you that I appreciate your giving exposure to the thoughts which I have expressed, for I believe that recognition of the changing trends in health care delivery as they are being experienced by all professions is most important, and only through meaningful dialogue between professions can we improve health care delivery and more effectively utilize our resources. We welcome the opportunity, Doctor, to share our views with you and the members of your profession.

Sincerely,
Robert C. Johnson, R.Ph.
Executive Director
Michigan State Pharmaceutical Association

* * *

Dear Mr. Johnson:

Thank you for your letter of January 16th. Your letter has some very interesting points. We welcome the pharmacist as a part of the health team and recognize the pharmacist has been a valuable member of the team through the years. Throughout your letter you point out the need for consultive service between physician and pharmacist and the need to work together as part of the team. I completely concur with this. I would welcome the pharmacist playing a more active role in an advisory capacity. The pharmacist in our hospital plays a very active role in the overall planning of our activities.

In our changing patterns of providing medical care the physician is coming to rely more and more on working with other professionals to help furnish health care. The physician, however, must remain "captain of the ship," utilizing the knowledge of all associated with him, to eventually care for the sick. He cannot abrogate therapeusis to others.

Certainly the pharmacist should take a greater role in education. He is in an ideal position to help educate the general public about efficacy of drugs, cost of drugs, self-medication, etc. He should also play a role in education of physicians, especially in the hospital pharmacist relationship.

Our two groups cannot work without each other and the relationship must be that of mutual admiration and trust.

Sincerely,
John W. Moses, M.D.
Scientific Editor
Michigan Medicine

Detroit Receiving Meets Accreditation Committee's Suggestions

Recommendations of the Joint Hospital Accreditation Committee of Chicago have been effected by Receiving Branch, Detroit General Hospital, according to Edward P. Henry, hospital administrator.

Action to meet the recommendations was taken after the joint committee granted the hospital only a one-year extension of accreditation for 1969, instead of the usual three-year extension. Another such one-year approval would make the hospital subject to losing its accreditation which could lead to its closing.

Mr. Henry stated that he fully expects the hospital will be granted a three-year renewal of accreditation next year. The hospital is still fully approved, he pointed out.

Two From MSU Med School Address Nursing Supervisors

Two members of the Michigan State University College of Human Medicine faculty were speakers at the recent workshop for nursing supervisors and department heads at Kellogg Center, East Lansing.

L. George Suhrland, M.D., discussed "Trends in the Provision of Health Services" and Ronald W. Richards, M.D., talked about "How to Give Instructions and Improve Communications between M.D. and R.N."

Dr. Dudzinski Takes Post At Mt. Clemens Hospital

Edmund J. Dudzinski, M.D., New Baltimore, is now full-time medical director at Martha T. Berry Hospital in Mt. Clemens, a post he has held part-time since appointment in January, 1968. Doctor Dudzinski retired from private practice in January after over 34 years of service in New Baltimore.



The Fortunate One.

Her urinary tract infection reveals itself through pain and discomfort.

While the pain and discomfort of a G.U. infection are anything but pleasant, the patient may be luckier than she realizes. That burning sensation (and/or frequency, urgency, dysuria) is a usually reliable sign of a urinary tract infection. And it's her good fortune that her infection won't go undetected...or untreated.

Azo Gantanol® therapy usually provides analgesic action within one-half hour, while control of the infection begins within two hours. Azo, a specific urinary analgesic, soothes inflamed mucosa to give symptomatic relief. At the same time, the antibacterial component, Gantanol (sulfamethoxazole), achieves therapeutic levels in the blood and urine, with diffusion into interstitial fluids. Azo Gantanol—a good choice when urinary tract infection reveals itself through symptomatic distress.

Before prescribing, please consult complete product information, a summary of which appears on opposite page.

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Azo for the pain
Gantanol®
(sulfamethoxazole)
for the pathogens

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets morning and evening.

How Supplied: Tablets, bottles of 50.



Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

MSMS Members In the News

Edgar A. Kahn, M.D., Ann Arbor,
is one of four U. S. physicians whose comments on surgical treatment of brain hemorrhage are included in the Jan. 27 issue of *Modern Medicine*. Doctor Kahn is a neurological surgeon with University Hospital, Ann Arbor.

W. G. Gamble, Jr., M.D., Bay City,
has been awarded the status of a Fellow Emeritus in the American College of Cardiology.

Kenneth John Williams, M.D.,
former medical director of St. John Hospital, Detroit, is new director of medical affairs for the Catholic Hospital Association of St. Louis, Mo., effective in February.

Duane L. Waters, M.D., Manistique,
was reappointed by the governor recently for a new term on the State Corrections Commission. His term will end Dec. 31, 1972.

Myron E. Wegman, M.D., Ann Arbor,
recently was chosen chairman of the Federation of Associations of the Schools of the Health Professions. The Federation, staffed by the Association of American Medical Colleges, will confer again March 13.

Fred Sabin, M.D., Marquette,
recently was reappointed to the Northern Michigan University Board of Control for an eight-year term. He was first appointed in September, 1967. Doctor Sabin received a MSMS Certificate of Commendation at the 1968 House of Delegates for his volunteer leadership in education, civic affairs, etc.

Marjorie Peebles-Meyers, M.D., Detroit,
was presented an honorary doctor of science degree by Central Michigan University at its commencement exercises Jan. 25. Doctor Peebles-Meyers, MSMS Outstanding Physician of 1968, was also honored last year by being named one of the top 10 working women by the Greater Detroit Chamber of Commerce.

Joseph Francis Sadusk, M.D., Detroit,
vice president of medical and scientific affairs of Parke, Davis and Company, has been elected to the Board of Trustees of St. John Hospital. Doctor Sadusk is also clinical professor of medicine at the WSU School of Medicine.

M. A. Hoffs, M.D., Lake Odessa,
retired late in December after 40 years as the community's family doctor. He is former chief of staff and chief of surgery at both Ionia County Memorial Hospital and Pennock Hospital in Hastings and is a past-president of the Ionia-Montcalm Medical Society. He is currently a member of the MSMS Committee on Aging.



COUNTY SOCIETIES

Berrien to Show Marijuana Film

The Berrien County Medical Society elected at its January meeting to buy the AMA film describing the effects on young people of using marijuana. Russell J. Vastine, Jr., M.D., Buchanan, volunteered to take charge of the society's plans to show the film at area schools. The film was previewed by the society at a showing before the Berrien County Medical Society Auxiliary at Pawating Hospital in Niles.

Huron Doctors Community-Minded

Robert A. Willits, M.D., Elkton, secretary of the Huron County Medical Society, estimates that over one-fourth of the doctors in his county society are active in community organizations and local politics. They hold positions with such groups as school boards, regional planning commission, and county Democratic and Republican committees, he reports.

Jackson Society Co-sponsors Forum

The Jackson County Medical Society was a co-sponsor of a public forum on "Smoking and Health" Feb. 16 at Parkside High School. Speakers included Edward B. Diethrich, M.D., assistant professor of surgery at Baylor University's College of Medicine and Joseph Morris, M.D., Ann Arbor, thoracic surgeon. Joining them on a panel were Jackson internist Robert C. Corley, M.D., and Frank J. Schrader, M.D., specialist in gynecology and obstetrics.

Doctor Bryant Heads Genesee

Donald R. Bryant, M.D., succeeded H. Maxwell Golden, M.D., as president of the Genesee County Medical Society, at the society's annual Past President's Dinner recently. Both doctors are of Flint.

Doctor Fishbeck Installed

William A. Fishbeck, M.D., Traverse City, was installed as president of the Grand Traverse-Leelanau-Benzie County Medical Society at the organization's recent President's dinner at the Park Place Hotel in Traverse City. Wives of the members were guests as Joseph C. Steffey, M.D., Traverse City, conducted the ceremony. A talk by Paul Gikas, M.D., Ann Arbor, Chairman of the MSMS Committee on Highway Injuries, followed the installation.

Midland Sponsors Parents Classes

The Midland County Medical Society and the local Visiting Nurse Association are sponsoring a seven-week series of Expectant Couples Forums at the Midland Community Center. Movies, demonstrations and a tour of the Midland Hospital Maternity Department are included. G. James Yobst, M.D., of the society's Maternal and Child Health Committee is in charge of the speakers, who will include several doctors.

Oakland Society Hears Mickey Stanley

At their Father-and-Son meeting Feb. 5 at the Kingsley Inn, 300 members of the Oakland County Medical Society and guests heard Detroit Tiger Center Fielder Mickey Stanley discuss the "Tigers – 1968."

Bay County Hears Dr. Heustis

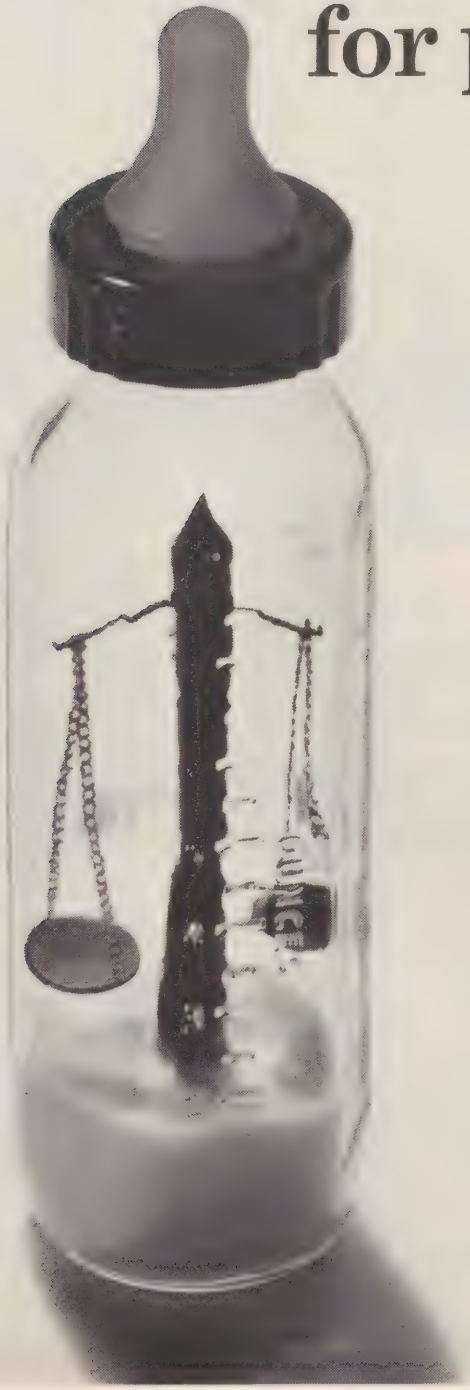
Members of the Bay County Medical Society heard a plea to start a regional medical program in heart disease, cancer and stroke at their January meeting. Their speaker was Albert E. Heustis, M.D., director of the Michigan Association for Regional Medical Program.

MSMS Highlights Ten Years Ago

- **G. B. Saltonstall, M.D., Charlevoix, served as MSMS President**
- **The cornerstone was laid for the present MSMS Headquarters in East Lansing**
- **The annual registration fee went into effect in 1959 for doctors, after recommendations by the MSMS House of Delegates**
- **The 1959 Michigan Clinical Institute featured a cataract operation over WWJ-TV**
- **Organizational efforts were continued during 1958-59 for the Michigan Association of the Professions**

— A Century of Service in Medicine By William J. Stapleton, Jr., M.D. Published by MSMS, 1965

Weigh these clinical observations on formula feeding for prematures



As you know, the primary goal of premature infant feeding is getting normal growth and development established as quickly as possible. The Gerber Baby Formula ...Modilac,™ (34 calories/fl. oz.) did this faster than any of the other formulas in Keitel and Chu's study.* Infants who weighed 2,000 gm. or less at birth actually gained weight faster than the *in utero* rate of normal infants. And more important this was normal development!



This study demonstrated that prematures on concentrated Gerber Baby Formula (34 calories/fl. oz.) achieved lean body weight as well as rapid weight gain. Edema or fat did not account for the increased weight in the infants.

The Gerber Baby Formula...a complete milk formula, comes in 13 fluid ounce cans. Undiluted, the Gerber Baby Formula provides 40 calories per fluid ounce. In normal (1:1) dilution formula provides 20 calories per fluid ounce.

To obtain 34 calories/fl. oz. add 2.3 fl. oz. of water to one 13 oz. can.

*Keitel, H. G. and Chu, E., Premature Infant Feeding I. The Clinical Usefulness of Caloric Concentration of Formulas, of Early versus Late Feedings and of Low Stearic Acid Content Formulas: The Pediatric Clinics of North America 12: 309 (May) 1965.

"Tomorrow in Today's Hands"
... through Gerber Research.

Gerber®

Gerber Products Company, Fremont, Mich. 49412

With the broad Polycillin (ampicillin trihydrate) spectrum...



...you have a lot going for you in the wide range of bacterial infections.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular.
Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).
Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.
Precautions. Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.
Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.
Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.
Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

11-1/2/69 **A.H.F.S. Category 8:12.16**

Polycillin®
(ampicillin trihydrate)

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

BRISTOL

The penicillin you use like a broad-spectrum antibiotic



For the "Cheater Eater"

Formulas: Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid (Warning, may be habit forming). Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital (Warning, may be habit forming).
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
Supplied: In bottles of 50.

Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

Spansule®

brand of sustained release capsules

curbs appetite
encourages normal activity
dispels diet discouragement

SK&F
Smith Kline & French Laboratories

IN MEMORIAM

Andrew H. Bracken, M.D.
Dearborn

Andrew H. Bracken, M.D., Dearborn physician for over 42 years, died late in December at the age of 70.

He was chief of general practice at Mount Carmel Hospital and had been a MSMS Delegate for two years. He was graduated from the University of Michigan Medical School and was a member of the American College of General Practice.

Harry H. Goldberg, M.D.
Detroit

Harry H. Goldberg, M.D., Detroit physician for many years, died Jan. 21 at the age of 79.

Doctor Goldberg was a graduate of Vanderbilt University School of Medicine and served with the Army Medical Corps in World War I.

Glenn C. Hicks, M.D.
Jackson

Glenn C. Hicks, M.D., Jackson physician for more than 50 years, died Jan. 3 at the age of 90.

Doctor Hicks, who was graduated from the Detroit College of Medicine in 1911, practiced in Jackson until his retirement Jan. 1, 1968. He was affiliated with Foote and Mercy hospitals in Jackson.

Doctor Hicks was a Life Member of MSMS and was a former president of the Jackson County Medical Society.

Theodore W. Ling, M.D.
Farmington

Theodore W. Ling, M.D., Farmington, died Jan. 17 at the age of 53.

Doctor Ling, specialist in obstetrics and gynecology in Birmingham for 11 years, was a member of the staff of William Beaumont Hospital, Royal Oak, and St. Joseph Mercy Hospital in Pontiac. He had formerly practiced in Farmington.

He was a graduate of the Tufts College Medical School and was a member of the American Board of Obstetricians and Gynecologists.

John E. Maczewski, M.D.
Grosse Pointe Woods

John E. Maczewski, M.D., Grosse Pointe Woods, former chief of staff of St. Francis Hospital, Hamtramck, died Jan. 15 at the age of 57.

Doctor Maczewski, also a member of Holy Cross Hospital staff in Detroit, was graduated from Wayne State University School of Medicine. He was a general practitioner who specialized in surgery and he held a certificate in surgery from the University of Pennsylvania School of Surgery.

He was a member of the American Society of Abdominal Surgeons, the Hawthorne Surgical Society and the Medical Dental Arts Club.

Louis J. Morand, M.D.
Detroit

Louis J. Morand, M.D., Detroit, died Jan. 16 at the age of 75.

Doctor Morand was a graduate of Detroit College of Medicine. He taught at Wayne State University School of Medicine, was a fellow of the American College of Surgeons and served on the staffs of several Detroit hospitals.

John H. O'Dell, Jr., M.D.
Three Rivers

John H. O'Dell, Jr., M.D., Three Rivers physician since 1949, died unexpectedly Dec. 28 at the age of 50.

Doctor O'Dell had been associated with the Three Rivers Medical Clinic since 1953 and was past chief of staff at Three Rivers Hospital. He was past president of the St. Joseph County Medical Society and served as city parks commissioner.

Doctor O'Dell was graduated from the University of Michigan Medical School and was a general practitioner.

Theodore B. Pauli, M.D.
Pontiac

Theodore B. Pauli, M.D., Pontiac physician and surgeon for nearly 30 years, died Jan. 21 at the age of 64.

Doctor Pauli, former chief of staff at Pontiac General Hospital, was graduated from Loyola University School of Medicine. He was a general practitioner and was also active on the staff of St. Joseph Mercy Hospital in Pontiac.

He was chairman of the board of directors of Oakland County Catholic Social Services and former treasurer of the Oakland County Medical Society.

Augustine J. Schenden, M.D.
Ann Arbor

Augustine J. Schenden, M.D., former health director of Melvindale for 25 years, died Jan. 20 at the age of 71. He had been living in Ann Arbor for several years.

Doctor Schenden had practiced medicine in Pinckney as well as Melvindale and was a graduate of the University of Michigan Medical School.

Fred L. Seger, M.D.
St. Petersburg, Fla.

Fred L. Seger, M.D., former chief of staff at Edward W. Sparrow Hospital, Lansing, died Jan. 2 in St. Petersburg, Fla., at the age of 94.

Doctor Seger, who founded the pediatric and obstetrics departments at St. Lawrence Hospital in Lansing, retired to St. Petersburg in the 1950s.

He was a former director of the Michigan Children's Aid Society and a past president of the Ingham County Medical Society. He was a graduate of the Detroit College of Medicine and was a general practitioner.

David B. Sher, M.D.
Jackson

David B. Sher, M.D., Jackson, retired Southern Michigan Prison physician, died Jan. 8 at the age of 70.

Doctor Sher was a physician at the prison from 1952 until he retired in 1962 and at one time was chief of staff doctors at the prison.

Gerhardus J. Stuart, M.D.
Grand Rapids

Gerhardus J. Stuart, M.D., psychiatrist in Grand Rapids for more than 50 years, died Jan. 10 in Palos Heights, Ill., at the age of 90.

Doctor Stuart, who was first psychiatrist at Pine Rest Christian Hospital in Cutlerville, was graduated from Rush Medical School in Chicago. He went into private practice in the 1920s and retired in 1958.

He was a member of the American Psychiatry Association and a Life Member of the AMA.

Bert Van Der Kolk, M.D.
Hopkins

Bert Van Der Kolk, M.D., long-time Hopkins doctor, died Dec. 29 in a Grand Rapids hospital at the age of 65.

Doctor Van Der Kolk, an American Board-certified radiologist, served at a number of Grand Rapids area hospitals until his retirement in 1967. He was an original member of the Allegan Health Center staff in Grand Rapids and was a general practitioner in Hopkins from 1935-1950.

He was graduated from Wayne State University Medical School, was a member of the American College of Radiology, the Detroit Roentgenology Ray Society and a former president of the Allegan County Medical Society.

Victor William Wallin, Jr., M.D.
Ann Arbor

Victor William Wallin, Jr., M.D., Ann Arbor, designated to be next chief surgical resident at University Hospital, was killed in a plane crash off the California coast Jan. 18. His wife, the former Beth Dohme, an instructor in nutrition at the U-M School of Public Health, also died in the accident.

Doctor Wallin was in his fourth year of residency in general surgery at the U-M Medical Center.

". . . We MUST do the educating. . ."

(Editor's Note: In an editorial in the Kalamazoo Academy of Medicine Bulletin, President Wm. D. Harrelson, M.D., wrote about current problems. In part, he wrote:)

"Problem #1. Action to relieve the local and state shortage of physicians.

"To accomplish this we must publicize the need and make every effort to get immediate approval of expansion of the Michigan State Medical School to four years. This would provide 62 MD graduates within two years and also facilities for training paramedical personnel which we so badly need. We must encourage all groups of people in our community, including our patients, to contact our local legislators and insist upon funds being provided for this purpose. It might be a good idea if you must turn down a prospective new patient, to let him know of the shortage and what needs to be done. In addition, we must make the climate in Kalamazoo attractive enough so that we may attract our fair share of physicians. The general public must learn to use their scarce medical manpower more realistically and *we* must do the educating. We must also follow Past President Robert Burrell's suggestion about group practice. We must accept the young physician's demand for security and provide partnership or group practice possibilities in Kalamazoo on an expanded scale. We must also support efforts to increase paramedical personnel of all types. Part of this support means individual teaching efforts by doctors, plus accepting the worth of these people and treating their efforts with the dignity they deserve."

Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

PSYCHIATRIC RESIDENCIES: Approved Three-year community oriented dynamic program in Metropolitan Detroit area. University associations. Teaching staff of Board men, psychoanalysts, professors, outstanding visiting lecturers. Active research. Modern physical plant. Salary $9,875; $10,445; $11,234. Five year career program $11,234 to $20,357. Liberal Civil Service benefits. Write: Director of Education and Research, Northville State Hospital, Northville, Michigan 48167.

MEDICAL DIRECTOR—Single County Health Department; population approximately 165,000. Department has 40 full time employees. V.D., T.B., and general health programs being followed. Good relations with local physicians. Excellent recreational and school facilities available. If under age 50, M.D., M.P.H. required. Over 50, 9 weeks of special training required within 3 years in lieu of M.P.H. Salary range $23,000 to $27,500, depending on qualifications and experience. Many fringe benefits. Send resume to James V. Wells, Chairman, Muskegon County Board of Health, County Building, Muskegon, Michigan 49440.

WANTED: Psychiatrist: Boards not mandatory; preferably under 40 years of age; Michigan license; to join 3-man private psychiatric group practice associated with private Psychiatric Hospital. Liberal salary first year, partnership later. Reply with autobiography. Box 332, Plainwell, Michigan 49080.

PSYCHIATRIC RESIDENCIES: Starting July 1969. Approved training in a mental institution with State of Michigan, Department of Mental Health. There are five year programs available. Salary $9,876-$11,233 and $11,254-$21,381. NIMH-GP stipends $12,000. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. For additional information, contact Dr. Paul Kauffman, Training Director, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

OPPORTUNITY FOR ORAL SURGEON. Only oral surgeon downtown, retiring from long established practice. All furnishings, equipment, records, three operatories, X-ray. Across from State Capitol, modern office, air-conditioned, reasonable rent. Easy terms, nothing down. Available in Spring. Contact Dr. B. E. Luck, 1512 Michigan National Tower, Lansing, Michigan (517) 484-3225.

INTERNIST — Board Certified or eligible. 269-bed General Medical and Surgical Hospital in Michigan's Upper Peninsula. Licensure any state, salary dependent upon background and qualifications. Excellent benefits for retirement, vacations, sick leave, and professional improvements. Non-discrimination in employment. Contact: Chief of Staff, VA Hospital, Iron Mountain, Michigan 49801.

FOR RENT: Office space in modern professional building on Lansing's far west side. Air conditioned with off street parking. Hospitals in city easily accessable from this location. Rent reasonable, other occupants a G. P. and a dentist. Phone 482-9440 area 517.

Two of the following 3 types of physicians needed immediately. $32,000 to $40,000 net first year for GENERAL SURGEON who would do some general practice; $30,000 to $35,000 net first year for INTERNIST who would do some general practice; $30,000 to $35,000 net first year for GENERAL PRACTITIONER capable of doing general surgery and salary open for GP inexperienced in general surgery. These first year incomes would be guaranteed and would depend on experience and qualifications. In addition would be included $500 worth of fringe benefits. These openings are available immediately or would sign contract if finishing residency in June. Partnership available at end of first year or sooner if agreeable. Absolutely no money needed to buy into full partnership. Would make excellent offer to two physicians who are now practicing together. Clinic net income relatively large because of high collection rate and exceedingly low overhead. Over 95% of patients are fully insured for any and all services rendered. All of the above is possible because of unique association between clinic and 3 large industries in town employing a total of 2100. Town of 3500 economically unsurpassed in many aspects located in NE Minnesota's beautiful Superior National Forest. Large unopposed clinic fully equipped in all aspects. Staff consists of 5 X-ray lab techs, 1 RN, and three secretaries. Good housing for rent or purchase. Liberal vacation and rotating night and weekend call. Fifteen minutes from modern hospital with radiology and pathology consultation. Excellent school system and most churches represented. Unexcelled hunting-fishing-snowmobiling-golfing-skiing-camping-boating-fresh air. All replies kept confidential. Call collect after 6 p.m. T. C. Leach, M.D., Babbitt, Minnesota 55706 (218) 827-6830.

G.P. Partner needed for growing practice in lower peninsula town of 2,000 population. Salary first year $20,000 and 50/50 partnership second year. Hunting, fishing, swimming, boating, skiing, canoeing, golfing nearby. Easy access to large population centers on new expressway. Reply Box 1, 120 West Saginaw Street, East Lansing, Michigan 48823.

Ferris State College is seeking an additional physician to complete the Staff of the Student Health Center. Attractive salary, fringe benefits, pleasant location, excellent facilities and working conditions. Please contact Roy A. Davis, M.D., (616) 796-8635 or write c/o Ferris State College, Big Rapids, Michigan 49307

Urgently needed: General physician, with or without sub-specialty in surgery, for group practice. Excellent salary, with partnership opportunities, rural living, with new 50 bed hospital adjacent to medical offices. Contact: L. A. Phelps, M.D., 10122 Janaroy Court, Goodrich, Michigan 48438, Phone (313) 636-2228

GP wanted for association with a surgeon and a well established general practitioner at Standish, Mich. New and progressive 80 bed hospital with CCU unit. Office space available. Financial arrangements open to discussion. Please call collect, Malcolm K. Dolbee, M.D., Area code 517-846-6122.

Index to Advertisers

They Help Make Michigan Medicine Possible

Abbott 202, 203, 204
Brighton Hospital 278
Bristol Laboratories 294
Brown Pharmaceuticals 279
Burroughs-Wellcome 247
Campbell Soup Co. 227
Classified Advertising 298
Geigy Pharmaceuticals 248, 249, 252, 270, 271, 272
Gerber 293
Hynson, Westcott & Dunnings, Inc. ..... Cover II
Ingram, G. A. Co. 267, 277
Lederle Laboratories 196, 204, 235, 239, 261, 262, 278
Lilly, Eli & Co. 208
McNeil Laboratories, Inc. 263
Medical Protective 267
Mercywood Hospital 299
Michigan Medical Service 198
National Drug Company 233, 284
Nuclear Research Associates 286, 287
Parke-Davis & Co. 281
Pitman-Moore Div., Dow Chemical Co. ... 264, 265
Plainwell Sanitarium 238
Poythress, Wm. P. & Co. 282, 284
Professional Management 244
Robins, A. H. & Co. 245, 278, 301, 302
Roche Laboratories ..... 236, 237, 250, 251, 290, 291, Cover IV
Roselawn Manor 277
Searle, G. D. & Co. 228, 229
Smith, Kline and French Laboratories 295
Strasenburgh Laboratories 230
Stratton, Ben P. ..... Cover III
Winthrop Labs. 283
Wyeth 274, 275

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road **Conducted by Sisters of Mercy** **Ann Arbor, Michigan**

Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

Lyle M. Allis, M.D.
Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.*
Sydney Joseph, M.D.
Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Richard D. Watkins, M.D.
Stephen C. Mason, M.D.
Philip M. Margolis, M.D.
Hubert Miller, M.D.

* 1904 - 1967

NOTES & QUOTES

BY HERB AUER, EXECUTIVE EDITOR

Michigan communities where students attend split shifts might consider a project at Stetson Junior High, Philadelphia, where the youngsters work three hours every morning at St. Christopher's Hospital for Children. "Many of the young underprivileged youngsters can see that a health career is attainable for them," a project official declares.

* * *

"The great challenge is for the continuing education of every member of the health team," contends Donald A. Williams, M.D., a Canadian authority on medical education. Doctor Williams points out that, no physician can function effectively unless each member of the health team also keeps up to date.

A paper "Maintenance of Academic Standards in Allied Health Education" by Ralph Kubli, of the AMA staff, from the AMA, 535 N. Dearborn, Chicago 60610.

* * *

"As responsible professionals dedicated to our patients' health our answer must be 'The Public Be Served.'" So writes F. P. Rhodes, M.D., in a recent issue of the *Detroit Medical News*.

* * *

An appeal for teamwork in the health field is made by D. F. Bledsoe, Midland, general manager of the Pitman-Moore Division of Dow Chemical, in a recent issue of the **Massachusetts Physician**. In part, Mr. Bledsoe wrote: "We pass the responsibility for the rising costs of Medicare back and forth between one another like a yo-yo. This does not solve our mutual problems — it aggravates them. It does not enlighten the public — it confuses them. It does not contribute to our image — it debases it."

The number of schools to which medical school applicants apply has increased steadily from 3.7 for the 1961-62 entering class to 5.0 for 1967-68. Among the 1967-68 applicants who took the MCAT, 97.5 percent applied to more than one school, according to the Association of American Medical Colleges.

* * *

A Wisconsin physician kept track of every medical journal



that arrived on his desk during a one-month period and reports that he had received:

487 pages in medical journals he had specifically subscribed to receive.

1,341 pages in JAMA and other organizational publications that he regularly receives as part of medical dues.

2,605 pages in medical journals that "just arrive," unsolicited.

———

4,433 total pages of medical journals — in just one month.

He says he enjoyed documenting the problem, but admits that he has no solutions to offer.

* * *

The Pitcher Elementary School in Detroit now has a picture of Zina Pitcher, M.D., hanging proudly in its halls. The sixth grade graduating class asked the *Detroit News* Contact 10 staff to find a photograph of Doctor Pitcher after whom the school was named. Contact 10 solicited the cooperation of the Detroit Art Institute photographer, Joseph Klima, who quickly pulled an old photo from the Burton Historical Collection at the main Detroit Library. A copy was quickly on its way to the school. Doctor Pitcher, who served as chief of staff at the old St. Mary's Hospital (now Detroit Memorial) died in 1872.

He served as one of the presidents of the Peninsular Medical Society, one of the forerunners of MSMS. The Peninsular Medical Society operated from 1853 after the old Michigan Medical Society failed until 1860 when so few members attended the annual convention that it disbanded. After the end of the Civil War, MSMS was organized in 1866 in Detroit in the old Odd Fellows Hall on Woodward between Congress and Larned where an official Michigan Historical Marker was placed during the 1966 MSMS Centennial session.

* * *

Complimentary copies of **Michigan Medicine** are presented each month to the three Michigan medical schools. The extra copies are sent in bundles to the Deans' Offices for distribution through the libraries, classrooms, lounge areas, etc. The MSMS Council and its Publication Committee believe this project helps develop closer relationships between the medical students and the state medical society.

* * *

American medicine is cooperating in eight ways to further reduce infant mortality, reports Donald E. Wood, M.D., Indianapolis, Chairman of the AMA Council on Legislative Activities. Doctor Wood supports government-private efforts for (1) Health education and the appropriate use of health facilities; (2) Improvement of living conditions among the needy; (3) Prenatal care of unwed mothers; (4) Family planning; (5) Research into the effect of nutritional influences; (6) National uniform registration statutes for births and deaths to bring about the collection of truly comparable statistics; (7) The development of immunological techniques; and (8) The advancement of genetic counseling programs.



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS



Owner Breaks Arm When Yacht Runs Aground

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm tially capsized. The fire departm had to rescue Waters by small bo Damage to the yacht is estimated

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



DESK REFERENCE CARD FOR STROKE ♥ INDEX

DIFFERENTIAL DIAGNOSIS OF STROKE 1

CEREBRAL THROMBOSIS 2-4

INTRACEREBRAL HEMORRHAGE 5-6

TRANSIENT ISCHEMIC ATTACKS 7-9

CEREBRAL EMBOLISM 10

SUBDURAL HEMATOMA 10

SUBARACHNOID HEMORRHAGE 11

Prepared by the Michigan Heart Association 3/69

Member: Michigan United Fund Affiliate: American Heart Association

DESK REFERENCE CARD FOR STROKE No. 1

DIFFERENTIAL DIAGNOSIS ♥

CEREBRAL THROMBOSIS is most frequently characterized by:

1. Onset during sleep or while inactive.
2. No headache.
3. Slow progression of symptoms.
4. Absence of neck stiffness.
5. Clear CSF.
6. Wide swings in blood pressure.
7. Previous episodes of a transient nature. See Card No. 7.

CEREBRAL EMBOLISM is most frequently characterized by:

1. Onset sudden.
2. No headache.
3. Signs maximal at beginning, but repeated embolic episodes may occur.
4. Absence of neck stiffness.
5. Clear CSF.
6. No previous episodes of transient cerebral vascular insufficiency. See Card No. 7.
7. Underlying heart disease usually present, or mural thrombi on plaques of the carotid and vertebral arteries in the neck.

(OVER)

Prepared by the Michigan Heart Association

Member: Michigan United Fund Affiliate: American Heart Association

Cerebral vascular disease is a major problem in the United States. It accounts for 200,000 deaths every year and there are some 325,000 new cases in this country every year. There will be approximately 15,000 new cases in the State of Michigan annually. In 1964 it was estimated that 2,000,000 people are living in the United States with residuals of stroke.

We are now in a position to provide active treatment for the stroke patient. Active treatment is available in all phases, from the acute stroke with its many medical problems, to the chronic stroke with problems of rehabilitation and the prevention of further attacks.

These cards prepared by the Stroke Committee of the Michigan Heart Association are designed to supply information about common problems encountered on stroke in all its facets.

INTRACEREBRAL HEMORRHAGE is most frequently characterized by:

1. Headache, nausea, vomiting at the onset.
2. Onset with seizures.
3. Rapid deterioration to coma, Cheyne-Stokes respirations, hyperventilation, conjugate deviation of eyes, dilatation of one pupil due to brain stem compression.
4. Neck stiffness, bilateral extensor plantar response.
5. Blood or xanthochromia in CSF on spinal tap in 90%.
6. Hypertension at initial examination.
7. Usually occurs while patient is active.

SUBDURAL HEMATOMA mimics a stroke.

The following supports subdural hematoma:

1. History of head injury.
2. Headaches.
3. Fluctuation in level of consciousness.
4. Intellectual deterioration.
5. No neck stiffness.
6. CSF xanthochromic unless underlying brain contusion when it will be bloody.
7. Skull x-ray may show linear fracture.

CEREBRAL THROMBOSIS ♥

PATHOGENESIS: Arteriosclerosis, syphilitic endarteritis, polyarteritis nodosa, lupus erythematosis, temporal arteritis, polycythemia, hypercholesterolemia, hypertension, hypotension, elevated blood uric acid, diabetes mellitus, hypothyroidism, adrenal insufficiency, and trauma to the neck, may be some of the factors involved. Signs and symptoms vary according to the vessel involved and the efficiency of the collateral circulation. There may be previous episodes of a transient nature, see Card No. 7.

MIDDLE CEREBRAL ARTERY OCCLUSION:

1. Frequently occurs at night when asleep.
2. Main vessel occlusion onset sudden with coma or semicoma.
   Severe contralateral hemiparesis or hemiplegia.
   Severe contralateral sensory loss.
   If dominant hemisphere, speech disturbance.
3. Branch occlusions commonly produce variations in mental state (normal to stupor).
   Monoparesis of arm.
   Some variable sensory loss.
   Slight to severe speech disturbance.

(OVER)

Prepared by the Michigan Heart Association
Member: Michigan United Fund Affiliate: American Heart Association

TREATMENT OF CEREBRAL THROMBOSIS ♥

ACUTE STAGE: Patient Stuporous to Comatose.

I. VENTILATION:

a. Turn every 2 hours: from right lateral to left lateral to supine. Keep airway clear with careful suctioning. Remove dentures. If secretions accumulate and suctioning is needed frequently (e.g., every 10 or 15 minutes), tracheotomy is indicated. Tracheotomy should be done early; do not wait until anoxia and cyanosis develop.

b. Oxygen is needed only if the cardiac status makes it mandatory. Oxygen increases cerebral vasoconstriction.

c. Examine chest daily. Atelectasis is common. Postural drainage is helpful. Antibiotics are indicated.

II. BLOOD PRESSURE AND CARDIAC MANAGEMENT:

a. Hypertension: Treat cautiouslv.
   Reserpine 0.25 mg. IM q. 12 hours is usually effective.
   Aim for blood pressure: 140-160 systolic.
   Check B.P. hourly first 24 hours.

b. Hypotension: Give vasopresser agents. If no response, suspect adrenal insufficiency and give parenteral steroids.

(OVER)

Prepared by the Michigan Heart Association
Member: Michigan United Fund Affiliate: American Heart Association

INTERNAL CAROTID ARTERY OCCLUSION:

Symptoms vary according to efficiency of collateral circulation to ipsilateral hemisphere.

1. Collateral poor; sudden onset of coma with contralateral hemiplegia and hemi-hypalgesia. Mortality high, due to encephalomalacia→ edema→ uncal herniation→ secondary brain stem venous hemorrhage→ death.
2. Collateral moderately good: sudden onset of obtundity or stupor, hemiparesis, hemi-hypalgesia and severe speech disturbance if dominant hemisphere is involved.
3. Collateral good: may be asymptomatic or give minor symptoms which clear rapidly.

ANTERIOR CEREBRAL ARTERY OCCLUSION:

Not as common as carotid or middle cerebral occlusion.

1. Paresis or paralysis contralateral lower limb, with sensory deficit in that limb.
2. Urinary incontinence may occur.
3. Intellectual deterioration and personality changes.
4. Sucking and grasp reflexes common.
5. Involvement of upper limbs slight.

c. Cardiac
   1) Myocardial infarction is frequent. EKG is needed for diagnosis.
   2) Congestive heart failure and arrhythmias should be treated promptly.

III. BLADDER CARE:

a. Foley catheter always needed.
b. Irrigate catheter b.i.d.
c. After 24 hours clamp Foley, drain and re-clamp every 2 hours.
d. Accurate intake-output record is important.

IV. POSITIONING:

a. Turn patient every 2 hours for pulmonary prophylaxis and prevention of decubiti.
b. Use: 1) foot board to prevent tightness of heel cord, 2) sandbags to prevent external rotation at hip, 3) functional position of hand with hand roll, 4) pillow in axilla to prevent adduction deformity.
c. All limbs should be placed through full passive motion daily.
d. As soon as patient is conscious, cooperative and if physical therapist is available, start re-education and strengthening exercises of extremities. Attention should be given to maintenance of strength and mobility in non-affected extremity.

See No. 3-A

V. FEEDING:

a. First 24 hours give 3,000 cc. 5% dextrose in 0.2 N. saline I.V. (unless cardiac status a contra-indication).

b. Second 24 hours pass nasogastric tube and give 3,000 cc. water in divided amounts (e.g., 250 cc. every 2 hours).

c. Third 24 hours give 2,000 cc. blender diet plus water for total of 3,000 cc. fluid divided into 250 cc. every 2 hours via tube.

VI. IMPROVEMENT OF COLLATERAL CIRCULATION: Two preparations —intravenous papaverine or low molecular weight dextran may improve cerebral blood flow and collateral circulation to the ischemic area of the brain.

a. *Intravenous papaverine.* Infuse 500 mg. papaverine in 1000 ml. 5% dextrose and 0.2 normal saline over an 8 hour period. Keep I.V. open with slow infusion of 5% dextrose and 0.2 normal saline for 8 hours, then repeat infusion of 500 mg. papaverine in 8 hours. Alternate in this fashion for a 10-day period. Solution acts as an irritant producing phlebothrombosis unless infusion site is changed every 2 days.

(OVER)

TREATMENT OF CEREBRAL THROMBOSIS ♥

ACUTE STAGE: Patient Conscious

1. Attention to ventilation, blood pressure and cardiac management, bladder care, positioning, feeding and vaso-dilators as indicated on Card No. 3.

2. Institute or continue range of motion exercises and body positionings as indicated on Card No. 3, Section IV, "Positioning". ♥

3. Begin progressive activity several times a day to tolerance: (a) by teaching patient to turn from side to side; (b) come to sitting position and maintain balance; (c) stand and pivot on unaffected leg; (d) assume sitting position; (e) self-care — taking own bath; (f) teaching dressing and feeding activities.
   Use physical therapist, occupational therapist, registered nurse or rehabilitation nurse as available. Many local VNA's and health departments have such trained personnel.

(OVER)

Prepared by the Michigan Heart Association

Member: Michigan United Fund **Affiliate: American Heart Association**

b. *Low molecular weight dextran.* Patient is given a loading dose of 500 ml. 10% Dextran 40 in 5% dextrose I.V., over a one hour period (the loading dose). This is followed by an infusion of 500 ml. 10% Dextran 40 in 5% dextrose over a 12 hour period. This is repeated every 12 hours for 3-5 days.

The blood urea nitrogen and intake and output should be recorded daily. A sharp rise in BUN or oliguria is an indication to stop the infusion. Acute renal failure is a rare complication of low molecular weight dextran therapy.

VII. ANTICOAGULANTS AND THROMBOLYTIC AGENTS:

These are contra-indicated in the acute stroke.

4. Teach ambulation skills, starting by strengthening affected arm and unaffected extremities with standing and walking activities, progressing to stair climbing. Physical therapist if available is trained in these techniques.

5. Subluxation of scapulohumeral joint is common in hemiplegia. Prevent the subluxation with a hemiplegic sling as soon as patient is sitting up. See Card No. 2, "Directions for Hemiplegic Sling".

6. Braces. Should bracing be necessary, majority will need no more than a short leg brace to correct foot drop or inversion of foot at ankle. Consultation with a physiatrist or orthopedic surgeon is desirable when available.

7. Physicians, nurses and ancillary personnel should remember that a patient may be helped to understand if spoken to slowly, precisely and quietly. They fatigue easily — only a few questions at a time. Shouting is unnecessary and causes confusion. Baby talk is degrading and poor for morale.

8. Speech therapy may be of benefit, and if available should be utilized early.

DESK REFERENCE CARD FOR STROKE — No. 5

TREATMENT OF INTRACEREBRAL HEMORRHAGE ♥

Stuporous to Comatose

I. VENTILATION:

Flat in bed. Turn every two hours: from right lateral to left lateral to supine. Keep airway clear with careful suctioning. Remove dentures. If secretions accumulate and suctioning is needed frequently (e.g., every 10 or 15 minutes) tracheotomy is indicated. Tracheotomy should be done early; do not wait until anoxia and cyanosis develop.

II. BLOOD PRESSURE MANAGEMENT:

Reduction in blood pressure to 160 systolic is advisable. I.M. Reserpine is the drug of choice (suggested dosage is 0.25 mg. I.M. every six hours). If blood pressure is refractory to Reserpine, the following may be tried: Trimethaphan (Arfonad) I.V. (4 mg. per cc); giving 4 mg. per minute cautiously and continuously monitoring the blood pressure to avoid hypertension. Parenteral methyldopa (Aldomet) is also now available and may be tried. Extremely close observation is needed.

III. BLADDER CARE:

A. Foley catheter needed in stuporous or comatose patient.
B. Irrigate catheter BID with 10% Renacidin.
C. After 24 hours, clamp Foley, drain and re-clamp every two hours.
D. Accurate intake-output record is important.

(OVER)

Prepared by the Michigan Heart Association

Member: Michigan United Fund — Affiliate: American Heart Association

DESK REFERENCE CARD FOR STROKE — No. 6

TREATMENT OF INTRACEREBRAL HEMORRHAGE ♥

Conscious Patient

I. VENTILATION:

A. Turn every 2 hours: from right lateral to left lateral to supine. Keep airway clear with careful suctioning. Remove dentures. If secretions accumulate and suctioning is needed frequently (e.g., every 10 or 15 minutes), tracheotomy is indicated. Tracheotomy should be done early; do not wait until anoxia and cyanosis develop.

B. Oxygen is needed only if the cardiac status makes it mandatory. Oxygen increases cerebral vasoconstriction.

C. Examine chest daily. Atelectasis is common. Postural drainage is helpful. Antibiotics are indicated.

II. BLOOD PRESSURE MANAGEMENT:

A. Reduction of blood pressure to 160 systolic is desirable. Usually there is a good response to thiazides and reserpine.

III. BLADDER CARE:

A. Urinary output of at least 1,000 cc. daily is desirable.

(OVER)

Prepared by the Michigan Heart Association

Member: Michigan United Fund — Affiliate: American Heart Association

IV. POSITIONING:

A. Turn patient every 2 hours for pulmonary prophylaxis and prevention of decubiti.

B. Use: 1) foot board to prevent tightness of heel cord, 2) sandbags to prevent external rotation at hip, 3) functional position of hand with hand roll, 4) pillow in axilla to prevent adduction deformity.

C. All limbs should be placed through full range passive motion daily.

D. As soon as patient is conscious, cooperative and if physical therapist is available, start re-education and strengthening exercises of extremities. Attention should be given to maintenance of strength and mobility in non-affected extremity.

V. FEEDING:

First 24 hours, 3,000 cc., 5% dextrose and 0.2 N saline I.V. Second 24 hours pass nasogastric tube and give 3,000 cc. water (e.g., 250 cc. every 2 hours). Third 24 hours, give 2,000 cc. blender diet plus water for total of 3,000 cc. fluid divided into 250 cc. every 2 hours via tube. With return of consciousness, begin oral feedings as soon as possible.

VI. Examine chest daily. If signs of congestion or infection, use antibiotics as indicated. Postural drainage by elevating foot of bed 20 minutes q.i.d. is helpful.

VII. As patient improves, becomes conscious and cooperative, proceed as on Card No. 6.

IV. POSITIONING:

A. Turning, use of foot boards, sandbags at the hip, functional position of hand, full range of passive motion daily and re-education in strengthening exercises as indicated and described in Card No. 5.

V. FEEDING:

A. If oral intake is poor, supplement with I.V. fluids or tube feedings. Avoid dehydration. Patient usually needs 2,500-3,000 cc. daily.

VI. At the end of the first week, begin rehabilitation as outlined on Card No. 4.

LATER INVESTIGATION OF INTRACEREBRAL HEMORRHAGE:

Carried out during recovery phase while patient is under active physiotherapy and rehabilitation.

1. **Cardiac Status:** Chest x-ray, EKG, Decholin circulation time if congestive failure is suspected. Treating auricular fibrillation, reduces danger of emboli.
2. **Renal Status:** Urinalysis, BUN, PSP, IVP, creatine clearance as indicated.
3. **Sudden Hypertensive Crises:** Screen for pheochromocytoma with regitine or histamine as indicated or obtain catacholamine level, urinary VMA. Tyramine recently reported to be helpful.
4. Diabetes Mellitus may contribute to arteriosclerosis and should be controlled.
5. Blood dyscrasia may be etiological factor—bleeding time, coagulation time, prothrombin time, CBC and platelet count should be obtained.
6. Cerebral arteriography is indicated when presence of aneurysm, arteriovenous malformation (murmurs on auscultation over skull) or tumor is suspected.

DIAGNOSIS OF TRANSIENT ISCHEMIC ATTACKS ♥

I. Syndrome of Intermittent Insufficiency of Internal Carotid System.

Intermittent attacks of one or more of the following:

a. Weakness, paralysis or numbness of side opposite lesion.

b. Disorders of speech-dysphasia or aphasia: usually indicates left sided lesion.

c. Visual disturbance in ipsilateral eye: blindness or dim vision.

d. Confusion and impairment of consciousness may occur. Seizures are not common.

e. Deep tendon reflexes may be increased on opposite side.

f. Bruit (murmur) frequently present over affected carotid artery.

g. Ophthalmodynamomentry is helpful.

h. Carotid compression is contraindicated as a routine procedure.

(OVER)

Prepared by the Michigan Heart Association
Member: Michigan United Fund Affiliate: American Heart Association

INVESTIGATION OF TRANSIENT ISCHEMIC ATTACKS ♥

1. Lumbar puncture: fluid for cells, Pandy, protein, sugar, chlorides, colloidal gold and serology.
2. CBC: If anemic, investigate cause. A possible polycythemia vera needs verification by total blood volume estimation and bone marrow examination.
3. Blood and CSF serology. Meningovascular syphilis is on the increase.
4. Post prandial (2 hr.) blood sugar, and/or glucose tolerance test.
5. Serum uric acid: hyperuricemia is associated with atheromatous plaques in the neck vessels.
6. Serum cholesterol and, if indicated, other lipid studies.
7. EKG: ischemic changes, myocardial infarction, LV hypertrophy are common. Arrhythmias are also common. Clinical cardiac evaluation is important. If heart failure is suspected, Decholin circulation time and/or venous pressure estimation may be helpful.

(OVER)

Prepared by the Michigan Heart Association
Member: Michigan United Fund Affiliate: American Heart Association

II. Intermittent Insufficiency of Vertebral - basilar System.
Intermittent attacks of one or more of the following:

a. Ataxia of gait, particularly on getting out of bed or rising from a chair (The "blind staggers").

b. Dimness of vision, greying of vision, hemianopia or blindness.

c. Diplopia, ptosis, nystagmus.

d. Facial weakness.

e. Tinnitus and vertigo, nausea and vomiting.

f. Incoordination of limbs due to cerebellar involvement.

g. Occasional "drop" attacks with sudden loss of tone in lower limbs with or without loss of consciousness (e.g., "My knees give way and I fall.").

h. Difficulty in articulation (dysarthria) and swallowing (dysphagia).

i. Occipital headaches.

8. Record blood pressure, q. 1 hr., for 24 hrs. Treat if hypertensive peaks occur.
9. If hypotensive or if postural hypotension, investigate for pitultary/adrenal insufficiency: 24 hr. urine for 17 hydroxy keto steroids, 17 ketogenic steroids, urine response to ACTH stimulation test.
10. Hypothyroidism: PBI, radioactive iodine studies.
11. Chest x-ray: heart size, lung congestion, unsuspected tumor.
12. X-ray skull and cervical spine: pineal shift, cervical spondylosis causing compression of vertebral arteries.
13. EEG: may give a clue to brain tumor.
14. BUN: should be normal before injection of dye for cerebral angiography.
15. **Arteriography of all 4 cervical vessels, their intracranial branches and the arch of the aorta is indicated in all transcient ischemic attacks. It is probable that surgery will be helpful in averting a complete stroke in some of these patients.**

TREATMENT OF TRANSIENT ISCHEMIC ATTACKS ♥

Severe Cases: (Repeated intermittent symptoms of insufficiency, severe enough to confine patient to bed.)

1. **Surgery:** Surgical reconstruction of atherosclerotic carotid and vertebral arteries with stenosis is available in Michigan and should be considered in those cases of insufficiency deemed amenable on the basis of cerebral arteriography. Follow up studies currently indicate this group of patients benefits significantly.
2. Associated medical conditions should be treated, e.g. hypertension, anemia, polycythemia, obesity, diabetes mellitus, hypoglycemia, hypothyroidism, hyperuricemia.
3. **Anticoagulants:** While contraindicated in the acute stroke, may be of benefit in transient ischemic attacks. It is usual to begin with Heparin and an oral anticoagulant, discontinuing Heparin when the prothrombin time is lowered to therapeutic levels. Recent reports advise discontinuing anticoagulants after six months to a year.
4. **Others:** Intravenous Papaverine, isoxsuprine hydrochloride (Vasodilan) and 5 percent CO_2 inhalations are under renewed interest and investigation.

Prepared by the Michigan Heart Association
Member: Michigan United Fund Affiliate: American Heart Association

CHRONIC SUBDURAL HEMATOMA ♥

Pathogenesis:

Almost always due to head injury, but may occur in blood dyscrasias and long term anticoagulant therapy.

Symptoms:

1. History of head injury may not be obtained.
2. Headache, confusion, varying level of consciousness.
3. Hemiparesis common.
4. A deepening coma has grave prognostic significance and occurs as intracranial pressure rises.

Signs:

1. X-ray of skull: calcified pineal may be displaced.
2. Cerebrospinal fluid is usually xanthochromic, but may be bloody. Occasionally it is clear.
3. EEG usually shows voltage differences between the two hemispheres. (OVER)

Prepared by the Michigan Heart Association
Member: Michigan United Fund Affiliate: American Heart Association

Diagnosis:

Depends upon high degree of suspicion in all patients with clouding of consciousness, especially in the elderly and in the alcoholic. X-ray of skull is mandatory in all cases of suspected head injury. Diagnosis finally depends upon cerebral arteriography or pneumonencephalography.

Treatment:

Surgical drainage of hematoma.

SUBARACHNOID HEMORRHAGE ♥

Pathogenesis:

1. Rupture of meningeal vessels due to head trauma.
2. Rupture of intracranial aneurysm.
3. Rupture of vascular anomaly (arterio-venous malformation).
4. Intracerebral hemorrhage with extension to subarachnoid space (hypertension).
5. Rarer causes, i.e., blood dyscrasia, anticoagulant drugs, intracranial tumors, sicklemia, pseudoxamthoma elasticum, Ehlers Danlos syndrome, Sturge Weber, etc.

Symptoms and Signs of Spontaneous Subarachnoid Hemorrhage:

1. **Sudden onset** (in 90% of cases) with severe **headache** and rapid development of confusion, stupor or coma. **Nuchal rigidity.**
2. **Bleeding into substance of brain:** Gives picture of confusion, restlessness (frontal lobe), hemiparesis, aphasia (fronto-parieto-temporal).
3. **Local pressure:** Cranial nerve palsies, third nerve commonest site **(unilateral dilated pupil)** in posterior communicating aneurysm.
4. **Subhyaloid hemorrhages:** In anterior communicating artery aneurysm. Funduscopy diagnostic.
5. Pyrexia and hypertension are common.

(OVER)

Prepared by the Michigan Heart Association

Member: Michigan United Fund Affiliate: American Heart Association

Dear Doctor:

Please check those items you would like to receive single copies of:

PATIENT EDUCATION

_____ If You Have Angina

✓ _____ Strike Back At Stroke

_____ Stroke, A Guide For The Family

_____ Aphasia And The Family

_____ After A Coronary

_____ Why Risk Heart Attack

_____ The Way To A Man's Heart (a collection of low cholesterol recipes)

PROFESSIONAL MATERIAL

_____ Rheumatic Fever Desk Reference Cards

_____ List of MHA Audio-Visual Material for Physicians

_____ MHA Research Grant Applic.

_____ Risk Factors and Coronary Disease: (a statement for physicians)

_____ Other _____ (specify)

Mail To _____ (please print) name

_____ address city zip

Laboratory:

CSF pressure increased, grossly bloody spinal fluid, **xanthochromic supernatant fluid after centrifugation.**

Mortality:

50% within first two weeks.

TREATMENT OF SUBARACHNOID HEMORRHAGE

1. Flat in bed. Can be turned gently for skin care and changing bed.
2. Adequate analgesics for headache. Demerol initially, later Codeine. Use Phenothiazine with these drugs to prevent vomiting.
3. Phenobarbital for restlessness.
4. Foley catheter. Irrigate with 10% Renacidin, b.i.d. After 24 hrs. clamp Foley, drain, and reclamp Q 2 hr. **Note:** Distended bladder is potent cause of restlessness.
5. If patient is conscious, liquid diet; patient fed by nurse, flat in bed.
6. If stuporous or comatose, I.V. fluids, 2,500-3,000 cc. daily, 5% dextrose in 0.2 saline, with 20 mEq KCL to each 1000 cc. Adjust as indicated by electrolyte studies.
7. Accurate intake and output chart.
8. Reduce and maintain B.P. at or about 140-160 mm. Hg. systolic or with Reserpine (1M or PO); 0.25 mg. Add Arfonad or Aldomet if needed. Check B.P. hourly first 24 hrs.
9. After 3 days, if still comatose, pass nasogastric tube and feed blender diet in 3,000 cc. fluid. Stop the I.V. fluids. See Card No. 3, under **Feeding, 5c.**
10. Cerebral arteriography to localize lesion. Surgery if indicated.
11. If inoperable, continue complete bed rest a total of 6 weeks.

Postage Will be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY MAIL
First Class Permit No. 14993, Detroit, Michigan

MICHIGAN HEART ASSOCIATION

13100 PURITAN AVE.

DETROIT, MICHIGAN 48227

YOU ARE ENTITLED

TO COMPLETE SERVICE CONCERNING ANY OF THE

INSURANCE PLANS SPONSORED AND ENDORSED

BY THE

MICHIGAN STATE MEDICAL SOCIETY

Group Term Life

Group Long Term Disability

Professional Overhead Expense

Accidental Death And Dismemberment

Accident & Sickness Plan For Your Employees

The Ben P. Stratton Agency, Inc. also provides complete insurance service for Professional Corporations, Partnerships, or Individuals. Your inquiries concerning valuable fringe benefits are invited.

Call collect, or write —

BEN P. STRATTON AGENCY, INC.

MSMS Insurance Administrators

P. O. Box 547, Lansing, Michigan 48903

Telephone: (517) 484-2578

Return Postage Guaranteed

MICHIGAN STATE MEDICAL SOCIETY
120 W. Saginaw
East Lansing, Michigan 48823

MJ
LIBRARY
U S PUB HEALTH SERVICE
WASHINGTON [illegible] 20000



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)
5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:

Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

MX 2 3 5

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

MARCH, 1969 • VOLUME 68 • NUMBER 6

JTC: MX 2
DATE: MAR 69
RUSH:
INPUT
AL LIBRARY OF MEDIC
APR 9 1969

HERE IS RUNDOWN OF FACTS AS MSMS SEES THEM

Osteopathic College Issue "Heats Up"

BY M. A. RILEY, MSMS LEGISLATIVE COUNSEL

Facts now show that Michigan's medical schools, given legislative support for growth already projected, are capable of adding one hundred and eighty-four (184) first-year places by the Fall of 1971! What's more, this expansion in opportunity for medical education can be achieved for less than $10,000,000!

The price tag on an Osteopathic institution capable of accomodating a maximum of 64 first-year places more than triples that demand on the State's funds.

Furthermore, all three medical schools have made it clear that, included in the expansion cost cited above, each can offer a student entering in 1971 his choice — in his final year of schooling — of either an MD or a DO degree!

PHYSICIAN MANPOWER BOOST CLEARLY NEEDED; COSTS ARE CRITICAL ISSUE

Facts — again — show that Michigan now enters 335 students as potential doctors in its medical education system per year — and ranks 15th in the U.S. in ratio of physician manpower to population. Everyone agrees that Michigan must quickly increase its production of physicians.

Based upon national population and medical school enrollment figures, Michigan should be entering between 600 and 630 students each year by 1975 in order to educate its fair share of the nation's doctors and improve its ranking among the States.

The central question is: How can our state most quickly, effectively, and economically expand its physician training facilities?

The question does not basically strike at philosophical differences between disciplines — or which institution comes "first" — but rather: HOW CAN THE HEALTH CARE NEEDS OF THE CITIZENS OF MICHIGAN BEST BE MET?

TAXES AND BUDGETS — DEMANDS AND COSTS

Pressure is definitely on for a new, independent Osteopathic college.

It's time to talk dollars and sense to everyone. It's time to talk to those who worry about tax increases and about growing government budgets — and who are entitled to, and should, demand that the Michigan Legislature spends their money with the greatest possible prudence.

Many if not all governmental agencies have increasing demands on public funds. It's time to talk to those who know the real needs of social service — to those deeply concerned about mental health problems and programs — to those interested in better public health — to the parents concerned about the needs of primary and secondary education in our State — to the conservationists who recognize problems in their field — in short, to everyone who is aware of ever-growing taxes and ever climbing budgets.

TAX FUNDS INVESTED NEEDLESSLY IN ONE AREA ARE DENIED OTHER IMPORTANT PROGRAMS!

DO SCHOOL SUPPORTERS ARE WRITING, TALKING, ACTIVE, PERSISTENT

Senate Bill 70 (and its twin in the House of Representatives, House Bill 2196), have triggered heavy mail to State legislators. There is an accelerating effort to hurry the DO college bill through the Legislature!

This bill calls for the State of Michigan to assume the total costs of a new college — no start on which has yet been made — for the sole purpose of educating Doctors of Osteopathy! By the time its first graduate was produced, the State of Michigan could have spent (or committed) in excess of $30,000,000 — assuming that an equal amount could be obtained from federal sources!

"OPTIONAL DEGREE" AN INNOVATION

The University of Michigan, Wayne State University, and Michigan State University are the first and only medical schools in the nation, to date, to offer to develop course work which would permit their students to "opt" for a degree in Osteopathy!

(Continued on 318)

Participate in this Health Planning Conference At Western Michigan University, Kalamazoo, April 16-17

MICHIGAN HEALTH PLANNING CONFERENCE AND RELATED SUBJECTS (Continued)

HEALTH MANPOWER AND HEALTH EDUCATION

- How to Plan for Health Education; William N. Hubbard, Jr., M.D., Dean, University of Michigan Medical School
- How to Increase Health Education; W. Randolph Tucker, M.D., Association of American Medical Colleges
- How to Work with the Legislature for Health Education; Mr. Warren Huff, Michigan State University Board of Trustees

5:00 — Adjournment

7:30 — MSMS Committee Meetings

MSMS OFFICERS CONFERENCE

APRIL 17, 1969 (MSMS members only)

8:00 - 8:45 — Registration and Coffee

8:45 — Morning Session

Welcome — James J. Lightbody, M.D., President, MSMS

ECONOMICS AND THE PRACTICE OF MEDICINE

Presiding: James B. Blodgett, M.D., Speaker of the House

- Proposed Federal Tax Changes — a Significant Effect on Physician Economic Planning; Al Kushinsky, C.P.A., J.D., Manager, Tax Department, Alexander Grant and Company
- Federal Funds and the County Medical Society; Clyde T. Hardwick, MSMS Economic Consultant

ISSUES FACING MEDICAL PRACTITIONERS

- Legislative Issues and Answers; M. A. Riley, MSMS Legislative Agent
- Explanation of New AMA Decisions re D.O.'s, Interns, Residents; John C. Nunemaker, M.D., AMA

12:00 noon — Luncheon and Awards

- The Future Relationship Between Medicine and Osteopathy; Russell B. Roth, M.D., Vice-Speaker, AMA House of Delegates

2:30 — Adjournment

Second Class Postage Paid at Lansing, Mich.

Michigan Medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at Lansing, Michigan. Yearly subscription rate, $9.00. Printed in USA. All communications should be addressed to Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.
© 1969 Michigan State Medical Society.
Phone: Area Code 517, 337-1351.

MJ
LIBRARY
U S PUB HEALTH SERVICE
WASHINGTON D C 20000

WI
MI 223

STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

APRIL 1969 • VOLUME 68 • NUMBER 7

ALL PHYSICIANS ARE INVITED TO SECOND ANNUAL CONFERENCE FOR MICHIGAN HEALTH PLANNING AND RELATED SUBJECTS, DETAILS INSIDE ☐ SUPRAPUBIC CYSTOSTOMY IN GYNECOLOGIC SURGERY ☐ EDITORIAL — SOLVING MANPOWER SHORTAGE ☐ THE ROLE OF THE PHYSICIAN IN UTILIZATION REVIEW ☐ PULL OUT AND SAVE STROKE REHABILITATION CARDS

JTC: MX2
INDEXER: AP
VOL-ISS: 68-7
DATE: APR 69
DEPTH:
NON-DEPTH: X
RUSH:
SELECTIVE:

NATIONAL LIBRARY OF MEDICINE
RECD. APR 12 1969
INDEX
INPUT



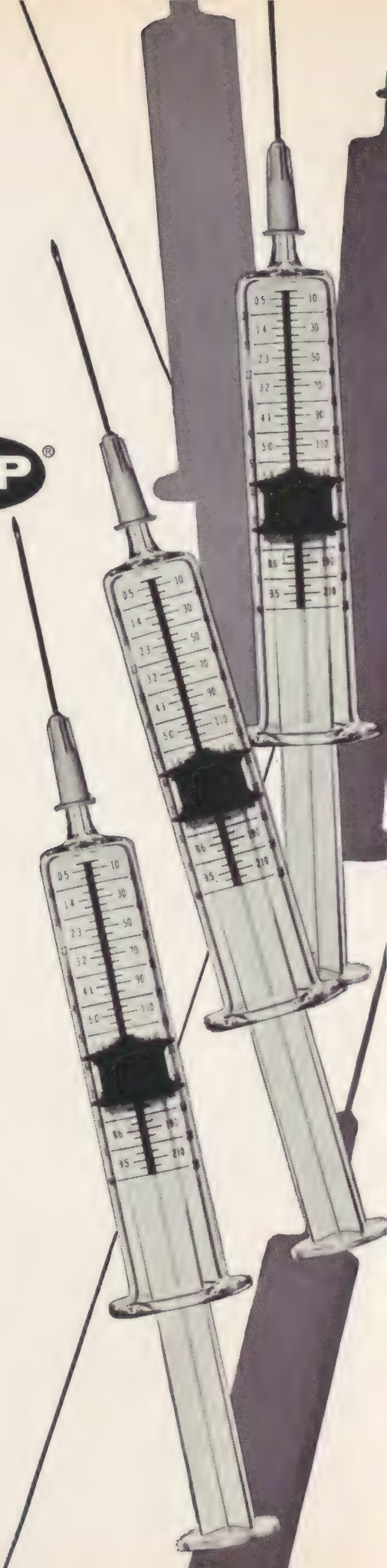
INDEX MEDICUS
JUN 20 1969

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



BROMSULPHALEIN®

IN A COMPLETE,

STERILE,

DISPOSABLE,

& ECONOMICAL

PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

The BSP Disposable Unit contains a sterile syringe with the dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized BSP solution. Each unit contains complete directions for use, precautions and contraindications.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor — the most costly commodities.

HYNSON, WESTCOTT & DUNNING, INC.

HW&D (BSPD3)

BALTIMORE, MARYLAND 21201

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

APRIL, 1969 • VOLUME 68 • NUMBER 7

SEE TABLE OF CONTENTS FOR THIS ISSUE, PAGE 327

Every MSMS Member Is Invited To Health Planning Conference April 16-17

Every MSMS member, and especially those with leadership responsibilities, is invited to participate in the "Second Annual Conference for Michigan Health Plannang and Related Subjects" at Kalamazoo, April 16-17.

"Subjects the first day, Wednesday, April 16, will pinpoint government health planning at all levels and how it relates to the private sector," according to Ross V. Taylor, M.D., chairman of the MSMS Council.

"The second day, Thursday, April 17, is reserved for county medical society officers and interested members. The program will include information about medical economics, legislation, costs of medical practice, legislative issues, and the question of the use of federal funds by county medical societies," adds Doctor Taylor.

The first day will be held at the functional Western Michigan University Student Center in the heart of the new campus area. The Southgate Motel, just off I-94 expressway on Westnedge, will be the headquarters hotel for the Wednesday night reception and buffet for all registrants and MSMS committee participants; and also for the program on Thursday.

Invitations have been extended to hospital administrators, government representatives, nurses, pharmacists and other paramedical personnel to participate the first day, April 16. In addition to the Michigan authorities obtained for the program, Ernest B. Howard, M.D., acting executive vice-president of the AMA, will come to discuss "Crystal Balling Federal Health Plans for 1969-70," and W. Randolph Tucker, M.D., of the Association of American Medical Colleges, will discuss "Ways of Increasing Health Manpower Production."

The Officers Leadership Conference program will offer Michigan experts talking about Michigan medical legislative issues, etc. Among the guest speakers will be Al Kuchinsky, C.P.A., J.D., manager of the tax department of the Alexander Grant and Company, on "Proposed Federal Tax Changes — A Significant Effect on Physician Economic Planning," and Boyd Thompson, executive director of the San Joaquin County Medical Society, California, on "Federal Funds and the County Medical Society."

Advance registration blanks were sent to all physicians in the March news extra, and are available from MSMS, 120 West Saginaw, East Lansing 48823.

The Student Center at Western Michigan University, Kalamazoo, will be headquarters for the Second Annual Conference for Michigan Health Planning and Related Subjects April 16; with the MSMS Officers Leadership Conference on April 17 at the Southgate Inn.



Children's Hospital Clinic Days

The Children's Hospital of Michigan has scheduled its 12th Annual Clinic Days, May 15 and 16 at the McGregor Memorial Conference Center, Wayne State University campus. Topics of the clinic will be Immunology and Hematology.

MSMS Requests Governor to Expedite Offer Of Medical Schools for Optional DO Degree

Governor William G. Milliken has been requested by the Michigan State Medical Society to ask the State Board of Education to call a conference to determine the requirements, so the three Michigan medical schools could offer an optional degree in osteopathy.

The optional degree approach along with expansion of the three medical school enrollments has been supported by the Governor, the three medical schools, and the Michigan State Medical Society. The State Board of Education on October 29 accepted a recommendation from its Citizens Committee on Education for Health Care, "recommending the continuation of the efforts directed toward the possibility of the existing medical schools offering MD-DO degree options by opening discussions with the three universities and with appropriate state and national organizations."

THE MSMS COUNCIL at its March meeting, took the formal action urging the Governor to seek a speed up of the discussions. The request was explained in a letter delivered to the governor on March 20.

THE GOVERNOR WAS requested in the letter from Doctor Taylor to ask the State Board of Education to call a conference soon on the curricula questions. Such a conference, the MSMS letter suggested, should include representatives of both the American Association of Medical Colleges and its national osteopathic equivalent, both the American Osteopathic and American Medical Associations, both the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgeons, also the three Michigan medical colleges and the proposed Michigan College of Osteopathic Medicine, and the State Board of Education and its Citizens Committee on Education for Health Care.

The three medical schools — University of Michigan, Wayne State University and Michigan State University — have reported to the State Board of Education the feasibility of such a new arrangement "by adding to the present curriculum at each school to meet the requirements of the DO degree," wrote Doctor Taylor. He declared that "both the state and national osteopathic bodies must and should be involved in the establishment of the curricula and facilities related to such an optional degree."

Governor Milliken in his executive budget message in January urged that "every effort should be made to encourage the two established medical schools and the new school at Michigan State University to provide training options for both the allopathic and osteopathic professions."

THE MSMS LETTER pointed out that "Michigan's medical schools are the first in the nation to indicate the feasibility of providing educational opportunity for those persons interested in obtaining the DO degree in an established university offering medical training."

The Governor was told that the suggested conference "would expedite the making available of additional educational opportunities for physicians in Michigan, for we recognize with you the developing critical manpower needs and wish to encourage every possible step to bring to fruition as soon as possible the training option which you urged in your budget message."

Governor Milliken in his January budget message also proposed financial support for expansion of medical education programs at the University of Michigan and Wayne State University and the allocation of funds for planning the clinical years of a four-year medical school at Michigan State University.

RUTGERS OFFERS SUMMER STIPENDS TO PHYSICIANS

Scholarships covering the total cost of tuition, room, and board are available from the Michigan Department of Public Health Alcoholism Program to Michigan physicians to attend the Rutgers Summer School of Alcohol Studies Physician's Institute.

Those interested may apply for scholarship consideration by writing to Mr. John McConnell, Education Director, Michigan Department of Public Health Alcoholism Program, 3500 North Logan, Lansing 48914. The deadline for submitting scholarship applications is April 14, 1969.

SECOND SET OF STROKE CARDS IN THIS ISSUE

The second set of **Desk Reference Cards for Stroke**, designed for easy removal and insertion in a doctor's own filing system, is included in this April issue of *Michigan Medicine*.

Dealing with the rehabilitation of stroke patients, the cards are on stock just inside the back cover. They have been revised and are published here by the Stroke Committee of the Michigan Heart Association.

The first set, beginning with differential diagnosis, supplied in a condensed fashion the latest information on the active treatment of the many medical problems of acute cerebral vascular disease. Both sets, along with a group of cards dealing with Rheumatic Fever and Heart Disease, are available without charge on request to the Michigan Heart Association, a Michigan United Fund Agency.

Postgraduate Lectures This Spring

Continuing medical education programs will be offered this spring in 19 communities by the MSMS Committee on Postgraduate Medical Education.

Each spring and fall MSMS sends outstanding medical educators from the three Michigan Medical schools to different counties. Most of the programs will open with a wet clinic and demonstration in the afternoon, followed by a more formal lecture in the evening.

MSMS members are invited to attend any of the programs. A program folder listing the events is mailed to all the MSMS members in the areas being served. These postgraduate programs are not offered in the large metropolitan areas where many courses are available from medical schools and hospitals.

The following list is announced by Harry A. Towsley, M.D., chairman of the MSMS PG Committee:

Ottawa County, Friday, April 4
Port Huron, Tuesday, April 8
Alpena, Thursday, April 24
Grayling, Wednesday, April 30
Battle Creek, Tuesday, May 6
Livingston County, Wednesday, May 14
Midland, Thursday, May 15
Sault Ste. Marie, Monday, May 19
Houghton, Monday, May 19
Escanaba, Tuesday, May 20
Manistique, Tuesday, May 20
Ironwood, Tuesday, May 20
Niles, Tuesday, May 20
Lansing, Tuesday, May 20
Iron Mountain, Wednesday, May 21
Menominee, Wednesday, May 21
Muskegon, Wednesday, May 21
Marquette, Thursday, May 22
Cadillac, Thursday, May 29

"Great Issues, Opportunities" To Key MAP's Annual Congress

"Great Issues, Great Opportunities" is the theme that will key the 10th Annual Congress of the Professions being sponsored by the Michigan Association of the Professions April 11 and 12 at the Jack Tar Hotel in Lansing.

The theme will be carried through talks by distinguished national figures, awards presentations to leading Michigan professional men and meetings of the American Association of the Professions, which will be incorporated in the Congress.

Among the men who have consented to speak is The Hon. James D. Hittle, Assistant Secretary of the Navy for Manpower (Designate). He is to discuss specifically the war in Vietnam.

Harry A. Towsley, M.D., Ann Arbor, will receive the MAP Distinguished Award during ceremonies the first day of the Congress. He is a nationally-known medical educator, pediatrician and civic leader.

John A. Hannah, newly-appointed director of the Agency for International Development and former president of Michigan State University for 28 years, will receive the MAP Outstanding Service Award. The past president's award will go to Gilbert Saltonstall, M.D., Charlevoix.

The general schedule of activities for the MAP Congress is as follows:

FRIDAY, APRIL 11

8 a.m.	Board of Directors Meeting and Breakfast
9:30 a.m.	MAP Annual Business Meeting
12 noon	Awards luncheon, with major speaker
2:30 p.m.	Panel discussion on Urban Affairs, Crime in the Streets, Education – Student Unrest, and War and Peace
5 p.m.	Reception and Cocktail Hour
6 p.m.	Dinner and Birthday Party, with major speaker

SATURDAY, APRIL 12

8:30 a.m.	AAP Breakfast
9 a.m.	AAP First Annual Meeting, consideration of bylaws and major speaker
11:30 a.m.	Adjournment



SEE DEMONSTRATIONS, TALK TO THE EXPERTS
AT MSMS CONFERENCE ON MEDICAL ASPECTS
OF HIGH SCHOOL SPORTS
THURSDAY, MAY 8 AT KELLOGG CENTER
MICHIGAN STATE UNIVERSITY



U-M, Henry Ford Hospital Make Plans to Affiliate

The University of Michigan and the Henry Ford Hospital in early March announced an affiliation agreement.

It followed several months of discussion between William N. Hubbard, Jr., M.D., dean of the U-M Medical School, and the medical and administrative leaders of Henry Ford Hospital.

Operating details of the affiliation were not explained. "In general, it is expected that U-M medical students will take part of their clinical studies at the Henry Ford Hospital under tutelage of staff physicians there," the U-M news announcement said.

"In addition, the Henry Ford Hospital staff will have access to U-M Medical Center facilities and resources for use in programs in which they are cooperating. Where appropriate, hospital physicians may be appointed to the U-M clinical faculty," the announcement added.

The U-M has committed itself to expand the Medical School enrollment to 300 students in each of four classes, from the present 205 as soon as possible.

Health Service and Flag Awards To Be Conference Highlights

Six "MSMS Outstanding Health Service Awards" will be presented as one of the highlights of the Second Annual Conference for Michigan Health Planning and Related Subjects at Kalamazoo, April 16-17.

The MSMS Awards Committee recommendations were approved by The MSMS Council, April 12 to also present the "MSMS Flag Awards" to seven Michigan physicians who are serving now as presidents of non-professional, state-wide organizations.

The Outstanding Health Service Awards for distinguished service in the field of medicine and health will be given to State Senator N. Lorraine Beebe, Dearborn Republican; State Representative Lucille McCollough, Dearborn Democrat; George C. Tosteson, M.D., Detroit, medical columnist; Larry Bush, *Ann Arbor News* science writer; *Jackson Citizen-Patriot* newspaper, and to Mel Barger, Jackson industrialist who has been a leader in the community effort there to obtain more physicians. These awards will be given at noon, April 16.

The Flag Awards, a new category started in 1968, will be presented April 17 at the MSMS officers workshop portion of the two-day Health Planning conference. Recipients will include Winthrop N. Davey, M.D., Ann Arbor, president of the Michigan Tuberculosis and Respiratory Disease Association; Michael Kozonis, M.D., Pontiac, president, Michigan Heart Association; Don Marshall, M.D., Kalamazoo, president, Michigan Association for Regional Medical Programs; Emanuel Tanay, M.D., Detroit, president, Michigan Association for Law and Psychiatry; E. Gifford Upjohn, M.D., Kalamazoo, president, Michigan Health Council; Fred W. Whitehouse, M.D., Detroit, president, Michigan Diabetes Association; and Alfred H. Whittaker, M.D., Detroit, president, Michigan Chapter of the American Medical Writers Association.

Doctor Fox Urges Workshop Participation

With the MSMS Eighth annual Medicine and Religion Workshop coming up soon on May 8 State Committee Chairman Winslow G. Fox, M.D., Ann Arbor, has mailed a letter to all presidents of county medical societies.

Doctor Fox urges that one or more doctors from each component society attend the 10 a.m. to 3 p.m. meeting at MSMS Headquarters, to join with members of the Medicine and Religion state committee.

In his letter, Doctor Fox includes a run-down of recent medicine and religion activities, as follows: "During the past year over one-third of the county medical societies have sponsored joint medicine and religion programs in which physicians and clergymen have met to discuss problems of patient care.

"These discussions have ranged broadly from the physician-pastor relationship to the patient and family, to the ethics of telling the patient the truth, the prolongation of life through extraordinary means, the patient's right to die, shared responsibilities of physicians and clergymen at death, the birth of a mongoloid, a terminal cancer patient, the unwed mother and abortion, drug addiction, etc.

"Program participation by doctors and clergymen has proven highly rewarding in establishing more knowledgeable, total patient care in today's fast-moving medical environment."

NATIONAL CONGRESS ASKS DOCTOR TAYLOR TO TAKE PART

Ross V. Taylor, M.D., chairman of the MSMS Council, was one of three members of a panel planned on the second day of the third National Congress on The Socio-Economics of Health Care March 28-29 at the Palmer House in Chicago.



JAMES J. LIGHTBODY, M.D.
PRESIDENT, 1968-69

All Those in Favor, Say "Ah-h-h-h"

Much of the important business of our state medical society is conducted through the diligent work and dedication of individual members of our numerous committees. Although our council conducts a tremendous amount of business at its monthly meeting, much of the discussion and interest centers around the reports of committees to the council.

One of the most important annual duties of the president of the society and the chairman of The Council, is the appointment of these committees and, particularly, choosing a chairman of each committee who is knowledgeable about the work of his particular committee. This year the president appointed 36 committees and the chairman of the council appointed 42 of the committees. They were just the regular committees that work throughout the year. When you add to them a rather large number of ad-hoc committees appointed for specific problems — and, the committees of the house of delegates appointed by the speaker — they add up to a tremendous number of meetings that certain doctors are supposed to attend.

Many of these same doctors are on local county medical society committees and probably other committees associated with other professional organizations and local civic activities. It is obviously impossible to get to all the meetings they are invited to. An effort is made, at least on the part of this state medical society, to schedule meetings only when there is business to consider, and to have them at times and places appropriate and convenient for committee members.

PHYSICIANS ARE INVITED to many organized gabfests because of the infinite number of organizations with which they have become involved to keep abreast of current events and all branches of professional interests. The number 1 hit on the hospital coat-room conversation parade is:

"Were you at that meeting last night?"

The usual meeting which is scheduled for seven o'clock starts about 7:30 by someone saying: "Well, we might as well start — it doesn't look as if anyone else is going to show up." So, the presiding worthy grand gavel pounder says: "The meeting is called to order." Then someone says: "I object — we don't have a quorum."

The secretary pro-tem is allowed ten minutes to peruse the bylaws which he does by calling his wife on the 'phone to look in the top dresser drawer and repeat section 5, article 7 on page 6 — which as amended states that: "Due to the exigencies of the manpower shortage and geographic variabilities of attendance — a quorum is considered to be two or more people who can put up with each other long enough to have a meeting."

ROUTINE PROCEDURE CALLS for the reading of the minutes of the previous meeting which, unfortunately, was held at Duffy's Tavern. According to the minutes it was a very short meeting but the attendance was unusually high.

The minutes are quickly approved so that the congregation can get down to the real business of the evening — the matter of adjournment. Someone makes a motion to adjourn and this is quickly amended by another motion to lay the previous motion on the table so that the question of special assessments could be considered. The chairman of the program committee of the evening, who is more or less completely out of order, announces that the guest speaker of the evening who was to talk on "Infections of the upper respiratory tract" is home in bed with a cold.

The motion for adjournment is then in order and the chairman of the committee, a nose and throat specialist, absent-mindedly says: "All those in favor, say AH-H-H."

Anyway, we want to publicly thank the chairmen and all the members of our hard-working committees and also the staff members who are assigned to each committee. Their work is greatly appreciated — and don't feel too badly if you can't get to all of the meetings to which you are invited.

PRESIDENT'S PAGE



He is a diabetic.
He is middle-aged.
When he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300 b.i.d.

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

345-H

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by Michigan Medicine. Michigan Medicine will pay the first $25 of the engraving bill, and the authors shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.

6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.

7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

8. Articles should ordinarily be less than four printed pages in length (3000 words).

9. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

10. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

IN THIS ISSUE

SCIENTIFIC ARTICLES

341 Suprapubic Cystostomy in Gynecologic Surgery; Morton R. Lazar, M.D., F.A.C.S., F.A.C.O.G., Eugene A. Snider, M.D.

345 Rhabdomyosarcoma: Report of 20 Cases; Lawrence S. Bizer, M.D.

349 Psychiatric Referrals In A General Hospital; Wiecher H. Van Houten, M.D.

353 The Sinai Hospital Low Vision Clinic; Morris J. Mintz, M.D., Ernest M. Gaynes, O.D., Arnold M. Gordon, O.D.

357 The Physician and Differential Diagnosis of Communicative Disorders in Children; Gerald S. Light, M.D., William Wolski, Ph.D.

SPECIAL ARTICLES

352 Longevity of Prominent Physicians

359 Hutzel Hospital Plans Centennial

370 Role of the Physician in Utilization Review; Richard A. Wahl, M.D.

388 Report from MSMS Auxiliary Health Careers Chairman

396 Grand Rapids Health Clinic Starts Second Year; William J. Schiffel

402 Detroit Pediatrician's Vietnam Experiences; Judith Marr

410 Michigan Communities Seek Doctors

ADD TO YOUR DIRECTORY: Committees of the Society, County Society Officers, Leaders of MSMS Sections, Pages 414-418

PRESIDENT'S PAGE

325 All in Favor Say 'Ah-h-h'; James J. Lightbody, M.D.

PHOTO SECTION, Pages 375 to 382, Inclusive

OTHER FEATURES

321 Breaking News

330 Our State Society

331 Mediscene

332 Committee Calendar

339 County Societies

344 Monthly Surveillance Report

348 Scientific Articles To Date

356 Michigan Authors

363 MSMS Members in the News

364 Editorial Views

390 Ancillary

400 New Members

418 In Memoriam

422 Notes and Quotes

Michigan Medicine

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at Lansing, Michigan. Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351.

© 1969 Michigan State Medical Society.



In Cervicitis

Help the healing process with StomAseptine® douching

Helps flush away exudates, maintain internal cleanliness, reduce odor...reassures the patient

StomAseptine douching is a valuable adjunct to cervicitis therapy. These gentle, non-irritating internal irrigations help maintain a clear field by washing away pus and secretions...relieve itching and burning...reduce malodor...and offer the patient a refreshing, reassuring procedure that can help speed the healing process.



Write for new booklet on patient douching instructions; space is provided for your specific recommendations. Advise quantity needed. Write: **Harcliffe Laboratories, Inc., Dept. 1003, 423 Atlantic Avenue, Brooklyn, N.Y. 11217**

STOMASEPTINE® DOUCHE POWDER

Contains: Sodium perborate, sodium bicarbonate, sodium chloride, sodium borate, menthol, thymol, eucalyptol, methyl salicylate and aromatics--Bottles of 6 oz., 15 oz., 32 oz., Cartons of 12, 10 Gm. Packets



MICHIGAN STATE MEDICAL SOCIETY

120 West Saginaw (P.O. Box 152)
East Lansing, Mich. 48823
Area Code 517, 337-1351

1010 Antietam Road
Detroit 48207
Area Code 313, 965-0541

PRESIDENT	James J. Lightbody, M.D.	Detroit
PRESIDENT-ELECT	Robert J. Mason, M.D.	Birmingham
SECRETARY	Kenneth H. Johnson, M.D.	Lansing
ASST. SECRETARY	Brooker L. Masters, M.D.	Fremont
TREASURER	John R. Ylvisaker, M.D.	Pontiac
ASST. TREASURER	C. Allen Payne, M.D.	Grand Rapids
SPEAKER	James B. Blodgett, M.D.	Detroit
VICE-SPEAKER	Vernon V. Bass, M.D.	Saginaw
PAST PRESIDENT	Bradley M. Harris, M.D.	Ypsilanti
COUNCIL CHR.	Ross V. Taylor, M.D.	Jackson
VICE-CHAIRMAN	Ralph R. Cooper, M.D.	Detroit

COUNCILORS:

Sidney Adler, M.D.	1st	Detroit
Ralph R. Cooper, M.D.	1st	Detroit
Don W. McLean, M.D.	1st	Detroit
Milton R. Weed, M.D.	1st	Grosse Pointe Park
Robert K. Whiteley, M.D.	1st	Detroit
Ross V. Taylor, M.D.	2nd	Jackson
Harvey C. Hansen, M.D.	3rd	Battle Creek
Don Marshall, M.D.	4th	Kalamazoo
John R. Pedden, M.D.	5th	Grand Rapids
Harold H. Hiscock, M.D.	6th	Flint
John J. Coury, M.D.	7th	Port Huron
A. Carl Stander, M.D.	8th	Saginaw
Robert V. Daugharty, M.D.	9th	Cadillac
Edward H. Rodda, M.D.	10th	Bay City
Brooker L. Masters, M.D.	11th	Fremont
Wm. A. LeMire, M.D.	12th	Escanaba
J. Robert Franck, Jr., M.D.	13th	Wakefield
Harold F. Falls, M.D.	14th	Ann Arbor
Sydney Scher, M.D.	15th	Mt. Clemens

EXECUTIVE DIRECTOR	Hugh W. Brenneman	East Lansing
ASSOCIATE EX. DIR.	Warren F. Tryloff	East Lansing
GENERAL COUNSEL	Lester P. Dodd	Detroit
LEGAL COUNSEL	A. Stewart Kerr	Detroit
ECON. CONSULTANT	Clyde T. Hardwick	Detroit
HISTORIAN	Wm. J. Stapleton, Jr., M.D.	Detroit
ASS'T HISTORIAN	Wm. M. LeFevre, M.D.	Muskegon

SCIENTIFIC EDITOR
John W. Moses, M.D., Detroit

EXECUTIVE EDITOR
Herbert A. Auer

MANAGING EDITOR
Judith Marr

ASSOCIATE SCIENTIFIC EDITORS
Frederick J. Cady, Jr., M.D., Surgery
Saginaw
Robert M. Daugherty, M.D., Basic Science
East Lansing
Harold E. De Pree, M.D., Medicine
Kalamazoo
Dean C. Elliott, M.D., Otolaryngology
Petoskey
Tommy N. Evans, M.D., Obst.-Gyn.
Detroit
Dorin L. Hinerman, M.D., Pathology
Ann Arbor
Samuel D. Jacobson, M.D., Medicine
Detroit
Benjamin Jeffries, M.D., Psychiatry
Detroit
Raymond S. Kurtzman, M.D., Radiology
Detroit
A. Martin Lerner, M.D., Medicine
Detroit
George H. Lowrey, M.D., Pediatrics
Ann Arbor
Carl A. Moyer, M.D., Surgery
Baraga
Charles E. Parkinson, M.D., Radiology
Battle Creek
John C. Pierce, M.D., Medicine
Grand Rapids
Frank H. Power, M.D., Surgery
Traverse City
J. G. Turcotte, M.D., Surgery
Ann Arbor
Alexander J. Walt, M.D., Surgery
Detroit
Park W. Willis, III, M.D., Medicine
Ann Arbor
Richard E. Wunsch, M.D., Medicine
Traverse City

Publication Committee

Brooker L. Masters, M.D.
Harvey C. Hansen, M.D.
William A. LeMire, M.D.
Don Marshall, M.D.
Don W. McLean, M.D.
Edward H. Rodda, M.D.
Milton R. Weed, M.D.



OUR STATE SOCIETY

Doctor Mason Reports Latest AMA ERF Statistics

MSMS President-Elect Robert J. Mason, M.D., Birmingham, has expressed his appreciation to Michigan doctors who have contributed to the AMA-Education and Research Foundation. He is Michigan AMA-ERF chairman and reported the following statistics to the MSMS Council:

(1) 19,300 medical students, hospital interns and residents now have $45,400,000.00 on loan from banks which have loaned the money because it was guaranteed by the AMA-ERF Loan Guarantee Fund;

(2) $18,677,000.00 has been given through the Foundation as unrestricted funds for medical schools during the past few years;

(3) The Institute for Biomedical Research has in three years of operation gained worldwide recognition as a center of excellence delving into basic life processes. Greater achievements are expected in the hoped-for expansion of the Institution.

MICHIGAN MEDICINE ARTICLES TO BE REPRINTED

MSMS has recently received two requests to reprint articles originally published in *Michigan Medicine*.

In addition, Wendell Weed of *Modern Medicine* magazine has written asking permission to abstract the article, "Early Management of Facial Nerve Trauma" by Roger Boles, M.D., Ann Arbor, which was published in the January issue of *Michigan Medicine*.

Meyer Schreiber, associate professor at Fordham University's School of Social Science in New York wrote for permission to reprint "Learning to Live in the Community," by C. Sower, which appeared in the December, 1959 issue.

Mrs. Gertrude Z. Enzweiler, director of health education for the Wayne County Department of Health, contacted MSMS asking to be allowed to reprint "What Is This Thing Called Health Education," by William H. Carlyon, Ph.D. It was published in the November, 1968, *Michigan Medicine*.

Here Is Opportunity To Ask Questions About Medicare

Michigan Medicine is initiating a "What Is Your Question?" section on Medicare, Medicaid policies, procedures and difficulties.

If sufficient inquiries are received it is hoped that other medical programs and subjects can be included for response by MSMS staff. Initially, only general questions can be accepted and individual problems about correctness of reimbursed fees are to be directed to Michigan Medical Service.

MSMS hopes you will detach the following form, fill it out and mail it in, and by this innovation stimulate and expand your interest and knowledge in every area of your concern.

Mail to: Question Box
c/o Michigan State Medical Society
120 W. Saginaw
East Lansing, Michigan 48823

My question is: _____

_____

Name _____

Address _____

RECOMMENDATION:

One of the greatest privileges as well as responsibilities of an individual physician is to participate in his county society, in his state society, and in the activities of the American Medical Association. To do this he needs to keep well informed and it is my sincere hope that every physician will devote that comparatively short time that it will take to review his county bulletin, **Michigan Medicine,** the AMA News, and JAMA.

Brooker L. Masters, M.D., Chairman
MSMS Publication Committee

MSMS LEADERS PARTICIPATE IN NATIONAL MEETING

MSMS President James J. Lightbody, M.D., and President-Elect Robert J. Mason, M.D., participated in the U.S. Chamber of Commerce Legislative Conference in Washington, D.C., Feb. 16-18. Theme of the conference was "Insight '69."

Doctor Lightbody and Doctor Mason said the tenor of the meeting "indicated that our government is attempting to correct the iniquities of the last administration and to start us upon a sound, functional basis in government.

"Appreciation was expressed by leaders of the National Chamber who were happy to have physicians interested in the total government welfare," the MSMS leaders reported.

MSMS Executive Director Hugh W. Brenneman and Ralph Wills, community relations director, also attended.

Community Hospital Authority Eliminates Reappointments

Using a 1968 MSMS House of Delegates resolution as a base, the Peoples Community Hospital Authority has eliminated completely its annual reappointment procedure for its medical staff.

MSMS Resolution 18 favored annual reappointment to the active medical staff specifying that such reappointment should not be denied except for medical ineptitude or character deficiency.

"We in the PCHA have gone a step farther," comments K. S. Klicka, M.D., medical director. "Henceforth, all appointments to our medical staff are continuous subject only to revocation with cause."

"It was our feeling as we developed our new by-laws," Doctor Klicka continues, "that physicians deserve equal security to hospital employees who, in general, have permanence in their position as long as they perform satisfactorily."

Michigan Mediscene

April 11-12 — Michigan Association of the Professions 10th Annual Congress of the Professions, Jack Tar Hotel, Lansing

April 11-12 — AMA Second National Conference on Nursing, AMA Headquarters, Chicago

April 11-12 — Michigan Heart Association 20th Annual Scientific Session, Sheraton-Cadillac Hotel, Detroit

April 16-17 — MSMS Second Annual Conference for Michigan Health Planning and Related Subjects, Student Center, Western Michigan University, Kalamazoo

April 19-20 — Michigan State Medical Assistants Society 12th Annual Educational Seminar, Holiday Inn, Muskegon

April 23 — Caucus, Michigan Delegation to the AMA, MSMS Headquarters, East Lansing

April 29 — Michigan Association of the Professions Annual Congressional Breakfast and Visitations, Rayburn Building, Washington, D.C., 8:15 a.m.

April 30 — MSMS Council, MSMS Headquarters, East Lansing, 10:30 a.m.

April 30 - May 1 — MSMS Woman's Auxiliary Spring Conference, Shanty Creek Lodge, Bellaire

May 1 — Conference for Medical and Education Reporters and Yates Lecture, MSU Kellogg Center

May 7-9 — Michigan Public Health Association Annual Meeting, Pick-Durant Hotel, Flint

May 8 — MSMS Annual Medicine and Religion Workshop, MSMS Headquarters, East Lansing, 10:30 a.m.

May 8 — MSMS Annual Conference on Medical Aspects of High School Athletics, Kellogg Center, Michigan State University, East Lansing

May 10 — Michigan Society of Pathologists, Mt. Sinai Hospital, Detroit, 1:30 p.m.

May 21 — Tenth Annual Muscle Symposium, Wayne County Medical Society Auditorium, 1010 Antietam, Detroit, 8 a.m.

May 22 — Wayne State University Alumni Clinic Day, Sheraton-Cadillac Hotel, Detroit

May 22-23 — MSMS Annual Maternal Health Conference, Gull Lake

June 4 — MSMS Council, MSMS Headquarters, East Lansing, 9:30 a.m.

June 25 — Caucus, Michigan Delegation to the AMA, MSMS Headquarters, East Lansing

July 13-17 — American Medical Association Annual Meeting, New York City

July 31-Aug. 2 — MSMS Midsummer Session of The Council, Boyne Mountain Lodge, Boyne Falls

Sept. 28-Oct. 3 — Michigan State Medical Society Annual Session, Sheraton-Cadillac Hotel, Detroit

Oct. 1 — MSMS Council, Sheraton-Cadillac Hotel, Detroit

Nov. 5 — Michigan Cancer Coordinating Committee, MSMS Headquarters, East Lansing, 2:00 p.m.

Plan to Attend these MSMS Events:

MSMS 8th ANNUAL CONFERENCE ON MATERNAL AND PERINATAL WELFARE
March 26-27; Pick Durant Hotel, Flint

MICHIGAN ASSOCIATION OF THE PROFESSIONS CONGRESS
April 11-12; Jack Tar Hotel, Lansing

MSMS 2nd ANNUAL CONFERENCE FOR MICHIGAN HEALTH PLANNING AND RELATED SUBJECTS
April 16-17; Western Michigan University, Student Center, Kalamazoo

MSMS 4th ANNUAL CONFERENCE ON MEDICAL ASPECTS OF HIGH SCHOOL SPORTS
May 8; MSU Kellogg Center, East Lansing

MSMS ANNUAL SESSION
September 28 - October 3; Sheraton Cadillac Hotel, Detroit

COMMITTEE CALENDAR

Every month many MSMS committees meet to develop new projects and to move along activities approved by The Council or suggested by the House of Delegates. Following is a calendar of March and April meetings for The MSMS Council, MSMS Committees and other official groups:

Wednesday, March 5
Committee on Public Health
MSMS Headquarters
Chairman: M. S. Reizen, M.D., Lansing
Wednesday, March 5
Committee on Mental Health
MSMS Headquarters
Chairman: Benjamin Jeffries, M.D., Harper Woods
Wednesday, March 12
The Council
MSMS Headquarters
Chairman: Ross V. Taylor, M.D., Jackson
Thursday, March 13
Committee on Respiratory Diseases
MSMS Headquarters
Chairman: R. A. Rasmussen, M.D., Grand Rapids
Thursday, March 20
Subcommittee on Lay Education (Of Maternal Health Committee)
MSMS Headquarters
Chairman: Richard T. Mellis, M.D., Kalamazoo
Thursday, March 20
Committee on Rehabilitation
MSMS Headquarters
Chairman: L. L. Davis, M.D., Mt. Pleasant
Tuesday-Wednesday, April 1-2
Liaison Committee with Michigan Chapter, Health Insurance Council
New Center Motor Lodge, Detroit
Chairman: John J. Coury, M.D., Port Huron
Wednesday, April 2
MSMS Committee on Cardiac Disease
MSMS Headquarters
Chairman: Sidney E. Chapin, M.D., Dearborn
Wednesday, April 9
MSMS Committee with State Bar of Michigan
Sheraton-Cadillac Hotel, Detroit
Chairman: Orlen J. Johnson, Bay City
Committee on Alcohol and Drug Dependence
MSMS Headquarters
Chairman: Herbert A. Raskin, M.D., Southfield
Wednesday, April 23
MSMS Committee to Study Health Problems of Disadvantaged in the Cities
Wayne County Medical Society Headquarters, Detroit
Chairman: Frank B. Walker, M.D., Grosse Pointe
MSMS Committee on Respiratory Diseases
MSMS Headquarters
Chairman: Richard A. Rasmussen, M.D., Grand Rapids
Thursday, April 24
Committee on Medical Aspects of Organized Athletics
MSMS Headquarters
Chairman: G. A. O'Connor, M.D., Ann Arbor
Thursday, April 24
Committee on Nursing
MSMS Headquarters
Chairman: R. L. Tupper, M.D., Pontiac
Thursday, April 30
The Council
MSMS Headquarters
Chairman: Ross V. Taylor, M.D., Jackson
Thursday, April 30
Judicial Commission
MSMS Headquarters
Chairman: Donald N. Sweeny, Jr., M.D., Detroit
Thursday-Sunday, May 1-4
MSMS Committee on Emergency and Disaster Medical Services
Sheraton-Cadillac Hotel, Detroit
Chairman: Charles P. Anderson, M.D., Detroit

MICHIGAN DOCTORS REAPPOINTED TO AMA COMMITTEES FOR 1969

The following Michigan doctors have been reappointed to one-year terms on AMA Committees by the AMA House of Delegates.

Council on Environmental and Public Health
Otto K. Engelke, M.D., Ann Arbor

Council on Health Manpower
Harold F. Falls, M.D., Ann Arbor

Committee on Alcoholism and Drug Dependence
Herbert A. Raskin, M.D., Detroit
Maurice H. Seevers, M.D., Ann Arbor

Council on Occupational Health
S. D. Steiner, M.D., Detroit

Committee on Occupational Toxicology
Bertram D. Dinman, M.D., Ann Arbor

AMA Disability Insurance Claims Review Committee
Donald N. Sweeny, Jr., M.D., Detroit

Committee on Medical Aspects of Sports
Richard C. Schneider, M.D., Ann Arbor

Committee on Rating of Mental and Physical Impairment (Subcommittee on Skin)
Donald J. Birmingham, M.D., Detroit (Chairman)

Committee on Rating of Mental and Physical Impairment (Subcommittee on Hematopoietic and Lymphatic Systems)
John W. Rebuck, M.D., Detroit

Joint Committee on Mental Health in Industry
Alexander H. Hirschfeld, M.D., Detroit



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS

Mild ulcerative colitis may be triggered here...



or here.



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and toler-. Though generally not recommended, if bination therapy with other psychotropics s indicated, carefully consider individual macologic effects, particularly in use of poating drugs such as MAO inhibitors and othiazines. Observe usual precautions in ence of impaired renal or hepatic function. doxical reactions (*e.g.*, excitement, stimulaand acute rage) have been reported in psyric patients. Employ usual precautions in ment of anxiety states with evidence of imling depression; suicidal tendencies may be nt and protective measures necessary. Vari- effects on blood coagulation have been ted very rarely in patients receiving the and oral anticoagulants; causal relationhas not been established clinically.

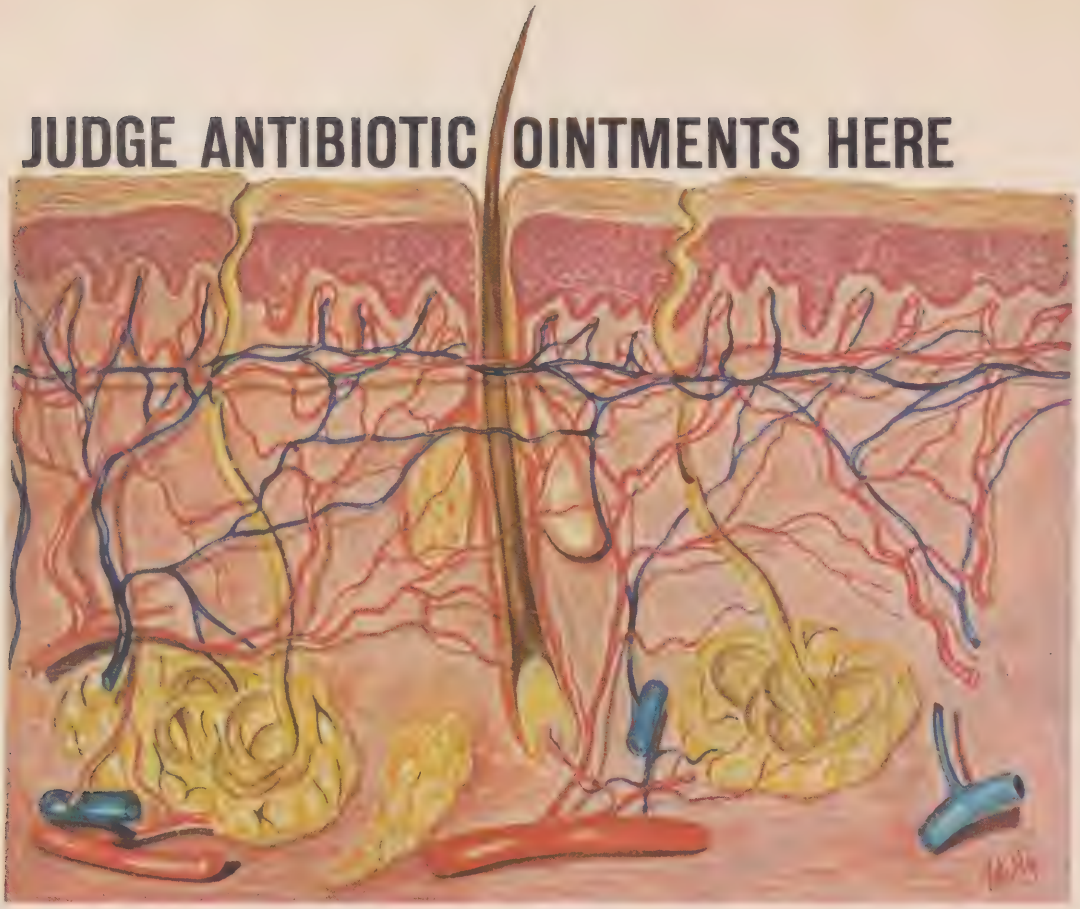
VERSE REACTIONS: No side effects or ifestations not seen with either compound have been reported with Librax. When rdiazepoxide hydrochloride is used alone, siness, ataxia and confusion may occur, cially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics, and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

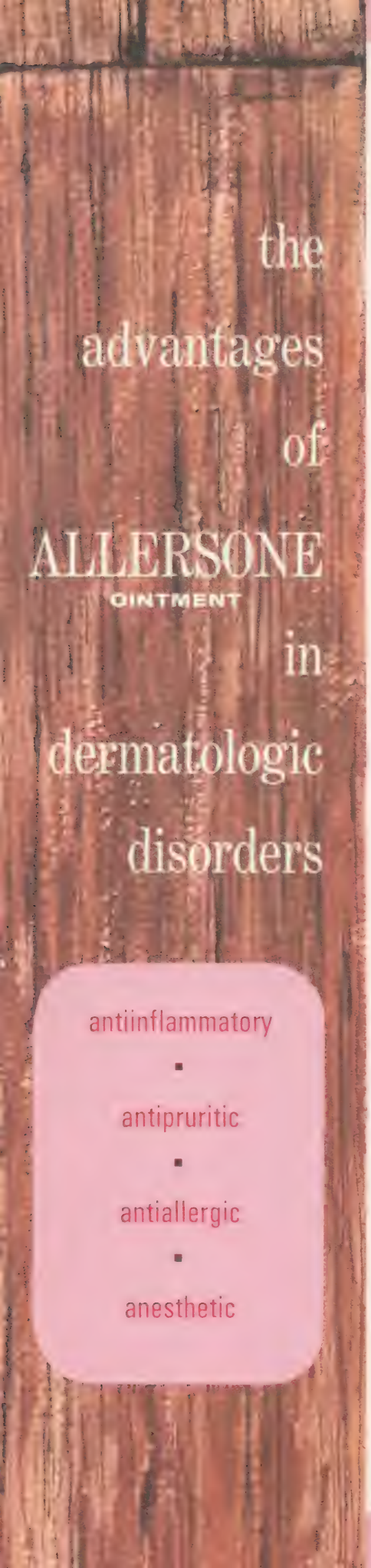
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



In dermatologic disorders...



IN THE MANAGEMENT of common dermatologic disorders, ALLERSONE provides more than symptomatic relief for your frustrated patient. Because ALLERSONE combines the antiinflammatory, antiallergic and antipruritic action of hydrocortisone with the anesthetic effect of diperodon HCl, it can make a worthwhile contribution to your therapeutic regimen.

ALLERSONE has long provided safe, effective and economical therapy for the anxious patient plagued by dermatologic problems. In addition, it is greaseless, odorless, colorless, as well as washable; thereby assuring a high degree of cosmetic acceptance.

ALLERSONE
OINTMENT

for effective topical management

COMPOSITION: Representing: Hydrocortisone 0.5%; Diperodon Hydrochloride 0.5%; Calamine 2.5%; Zinc Oxide 2.5% in a water-washable base containing sodium lauryl sulfate, propylene glycol, cetyl alcohol, white petrolatum, methylparaben and propylparaben as preservatives and water.

INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertrigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

ACTION: Hydrocortisone exhibits marked antiinflammatory activity when applied topically to the skin. It is ameliorative in pruritic, allergic and atopic skin lesions. Diperodon hydrochloride is a surface anesthetic, while the calamine and zinc oxide powders are well-known for their mild astringent and protective actions. The remaining ingredients comprise the water-washable base.

DOSAGE AND ADMINISTRATION: Distribute a small amount by gentle application over affected area, two or three times a day; frequency of application to be reduced with improvement.

CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain —while hydrocortisone reduces inflammation—in a water-washable vehicle —no desquamation from fats.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: 0.90 Allersone, pink ointment, available in 15 Gm. tubes and in pound jars.

MALLARD, INC.
PHARMACEUTICAL MANUFACTURERS
DETROIT, MICHIGAN 48216



COUNTY SOCIETIES

ALGER-MARQUETTE SOCIETY LED BY HARRY KOENIG, M.D.

New officers for 1969 have assumed duties in the Alger-Marquette Medical Society with Harry Koenig, M.D., Ishpeming, as president. He succeeds Charles K. Wright, M.D., Marquette. President-elect is Leonard S. Carefoot. M.D., Marquette.

Other officers are Firooz Emani, M.D., secretary, and Phillip E. Perkins, M.D., treasurer, both of Marquette.

DOCTOR COAK RECEIVES 'GOLDEN SHOVEL' AWARD

When all the suspense was over, it was Richard D. Coak, M.D., who was named recipient of this year's "Golden Shovel Award" for being the Lenawee County Medical Society member "with the most to say about everything."

The shovel, a full-size garden spade painted gold and decked with a red ribbon, was given and received in good faith at the LCMS annual meeting. Doctor Coak's name was engraved upon it.

Doctor Coak is our secretary and does a lot of work for us." said Francis Locke. M.D.. immediate past president. "And he does a lot of talking, too."

The first two recipients of the "Golden Shovel Award" were Xenophon Skufis, M.D., and Donato Sarapo, M.D.

CALHOUN UNIT CO-SPONSOR OF YOUTH TALENT SHOW

Among area associations sponsoring the 22nd annual Youth Talent Exhibit and Science Fair in Battle Creek April 6-13 is the Calhoun County Medical Society. The society will award a $25 savings bond to the exhibitor of the top medical display project.

JACKSON COUNTY HOSTS JOINT QUACKERY MEETING

Oliver Field, director of research for the AMA Department of Investigation, spoke on medical quackery at a recent meeting of Jackson County doctors, lawyers and dentists, sponsored by the Jackson County Medical Society. Mr. Field was also sponsored by the society at appearances before Jackson Rotarians and school children; and at a Jackson press conference.

IRVING SILVERMAN, M.D. INSTALLED BY INGHAM

The annual President's Night of the Ingham County Medical Society honored Irving Silverman, M.D., new president, at a dinner dance at the Jack Tar Hotel. Speakers included Roger Busfield, associate director of the Michigan Hospital Association; William Meade, M.D., immediate past president of the Society and Justin R. Sleight, M.D., president-elect.

GENESEE COUNTY MEMBERS SERVE ON SKI PATROL

The National Ski Patrol counts among its members several Flint-area doctors who belong to the Genesee County Medical Society. Those M.D.s who during the winter months sport the rust-colored jackets of the ski patrol as well as the white jackets of the profession, are John Wentworth, M.D., Robert Clark, M.D., Clayton Hurd, M.D., Alvin Judd, M.D., Richard McMurray, M.D., John Best, M.D., and Ross Collie, M.D. The men must work 26 hours on the slopes with a Ski Patrolman before taking a proficiency test in skiing and tobogganing that includes an exam in first aid.

DEAN HUBBARD ADDRESSES KALAMAZOO COUNTY

"Recent Developments in Medical School Curricula" was the topic of a talk delivered by William N. Hubbard, Jr., M.D., dean of the University of Michigan School of Medicine, at a Feb. 18 meeting of the Kalamazoo Academy of Medicine.

LENAWEE SOCIETY HONORS HOWARD HEFFRON, M.D.

After 43 years of practice in Adrian, Howard Heffron, M.D., received a plaque from the community and his fellow members of the Lenawee County Medical Society at the society's annual meeting in February. Marvin Wolf, M.D., was installed as new president, while speakers included Michigan Attorney General Frank Kelley, and Harold Falls, M.D., 14th District Counselor from Ann Arbor.


Darvon®
Compound-65
Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.
900252

Suprapubic Cystostomy In Gynecologic Surgery

BY MORTON R. LAZAR, M.D., F.A.C.S., F.A.C.O.G.
EUGENE A. SNIDER, M.D.
BOTH OF DETROIT

For many years, gynecologists have routinely used the transurethral retention catheter to insure adequate postoperative drainage of the urinary bladder. Because of the risk of urinary tract infection, however, the procedure has never been entirely satisfactory, especially for patients who have undergone vaginal surgery. Many variations have been suggested,[1] including repeated catheterizations, intermittent dependent drainage with the Foley catheter, three-way Foley drainage with antibiotic coverage, and sterile closed-system drainage.

In addition to infection, the indwelling catheter is frequently associated with pain, edema of the mucosa of urethra and trigone, suburethral perforation, delayed emptying of the bladder, persistent psychogenic delay in voiding, and the development of bacterial strains resistant to wide-spectrum antibiotics. Urologists, who are familiar with such complications, have long followed the practice of establishing drainage by way of cystostomy, particularly in male patients. The fact that the technique has been little used with gynecologic patients is probably due to several conditions — lack of knowledge of procedure (poor dissemination of knowledge between various specialties) and general complacency regarding infection and reliance upon antibiotic therapy.

In recent years evidence has accumulated suggesting that suprapubic cystostomy might provide the answer to many problems of urinary complications in gynecologic surgery. Of particular interest was the report published in 1966 by Hodgkinson[2] describing his technique for trocar suprapubic cystostomy and comparing his results in 98 cases with those in a similar series where transurethral catheterization was used. Stimulated by Hodgkinson's findings, we attempted to develop a similar procedure.

This paper reports the details of our method.

Surgical Procedures

Urologists customarily incise directly the distended bladder and insert a catheter which is held in place on the bladder wall by a purse-string suture; the abdominal wall is then closed in layers. Hodgkinson used a #20 trocar for puncturing the purposely distended bladder, after which a #12 Malecot catheter is inserted and connected to closed drainage. Several other authors, including Mattingly,[2] have used a 13-gauge needle and a #5 or #8 Bardex polyethylene feeding tube.

The technique which we have found most useful does not rely on distension for identification of the bladder wall, but rather upon a urethral sound which has been advanced into the bladder until the tip pushes against the bladder wall.[3] We employ a Guyon sound (**Fig. 1a**) modified by a hole drilled through the tip, and with a handle added for better control and to prevent turning. After the sound is passed into the bladder, the handle is displaced downward until the tip of the sound can be palpated just over the symphysis. Thus, the dome of the bladder is elevated and projects beneath the anterior abdominal wall. A small



Fig. 1a. Guyon sound with hole in tip

Doctor Lazar is Clinical Assistant Professor of Gynecology and Obstetrics at Wayne State University, School of Medicine and Affiliated Hospitals and is Vice-Chief, Department of Gynecology, Harper Hospital. Dr. Snider is Clinical Instructor of Gynecology and Obstetrics at Wayne State University, School of Medicine and Affiliated Hospitals.

Figure 1B

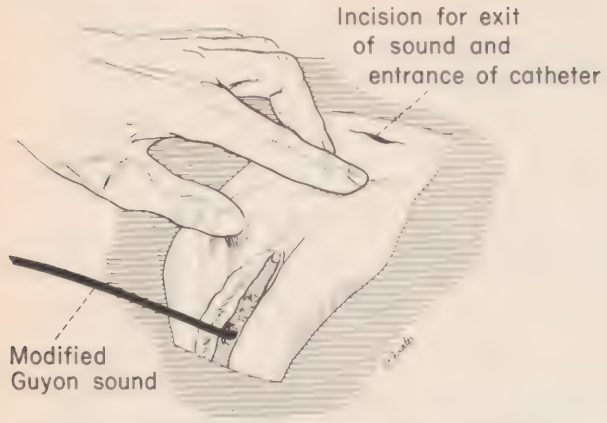


Figure 2

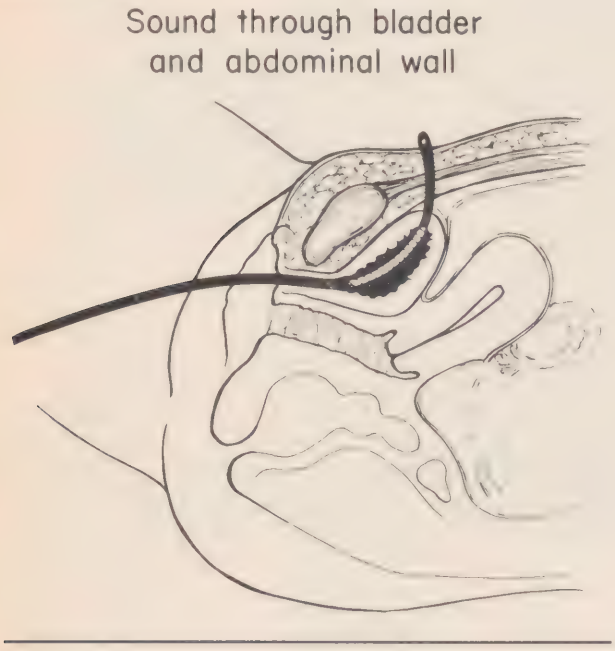


Figure 3

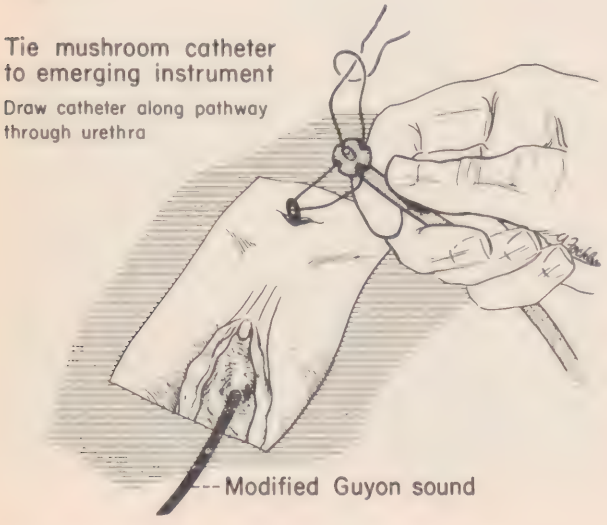


Figure 4

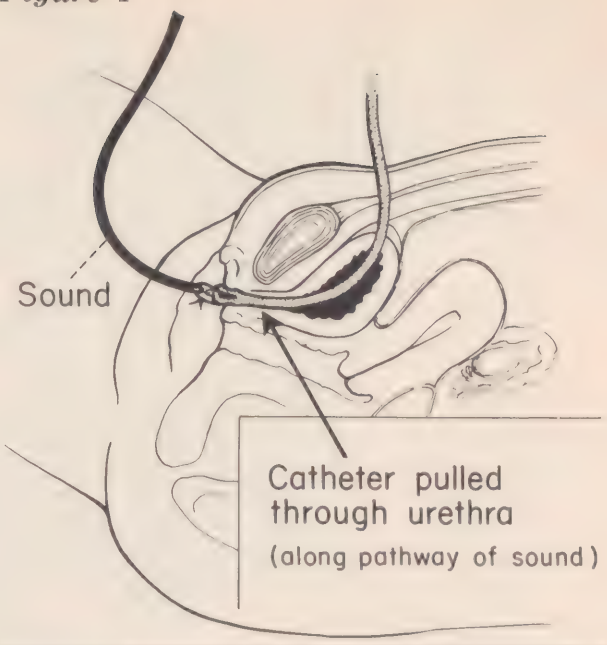


Figure 5

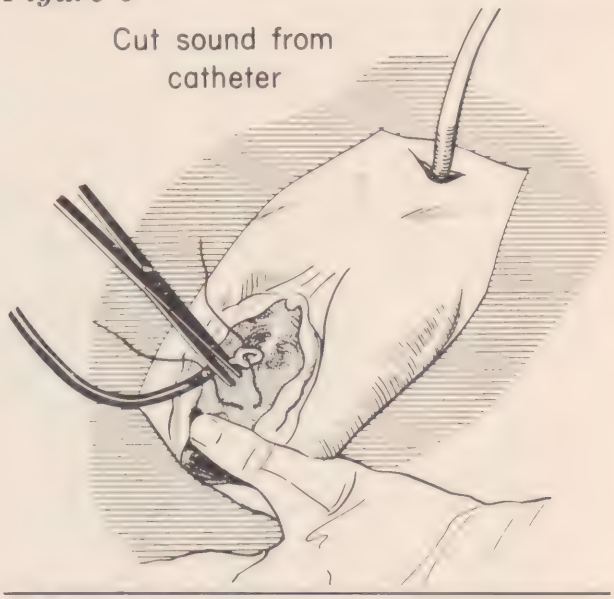
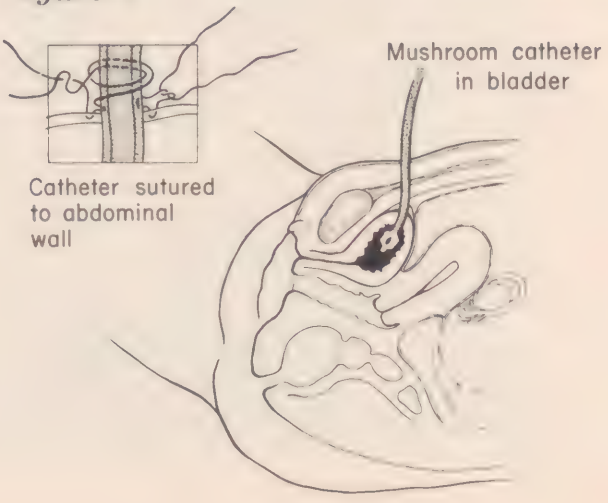


Figure 6



transverse incision (1 to 1½ inches) is made over the elevated area and carried through the fascia. (**Fig. 1b**). The bladder wall is nicked with the scalpel at the point where the sound is thrust upward against it, and the tip of the sound is then pushed through the abdominal incision (**Fig. 2**).

With heavy braided-silk suture, a #20 or #24 Malecot or mushroom catheter is tied loosely to the sound (**Fig. 3**). (If a mushroom catheter is used, additional holes are made in the head to allow easier manipulation and drainage.) The sound and catheter are then pulled back through the urethra until the catheter tip is visible at the urethral meatus. (**Fig. 4**). The suture between catheter and sound is then cut and the catheter is gently withdrawn back into the bladder. (**Fig. 5, 6**). Sterile milk is instilled to determine if the catheter is properly placed within the bladder by instilling 50 to 100 cc through the suprapubic catheter and noting its appearance through a French urethral catheter that is placed momentarily for this purpose. The abdominal wound is closed with one or two 00 silk sutures which fasten the catheter to the abdominal wall, guarding against displacement by accidental traction.

Post-operatively the catheter is irrigated with sterile water every 8 hours. After several days it is clamped for 2 or 3 hours at a time during waking hours. When the patient is able to urinate well, residual urine is checked by opening the suprapubic tube, and if the amount is less than 100 cc the tube is removed. Antibiotics are not administered prophylactically.

Technical Complications

Various difficulties can be encountered with the cystostomy tube: (1) Blood clots or debris may block the tube completely. We have not experienced this complication. (2) The catheter may become dislodged from the bladder into the surrounding tissue. This accident was the reason for changing from a Malecot catheter to the mushroom type early in our experience; the soft Malecot type was easily dislodged. For the same reasons we always test the placement of the catheter by the use of sterile milk at the end of the operation, to insure proper placement and drainage. (3) In several cases the silk suture has broken while the catheter was being pulled through the bladder into the urethra, so that it was necessary to pass the sound again and make a new opening in the bladder. No problems resulted from this accident, but, as a result, we always use heavy braided silk to attach the catheter to the sound.

We have not encountered any type of hematoma formation or bleeding from the bladder when this technique is used, and suturing the catheter into the abdominal incision has prevented dislodgment. The lack of antibiotic coverage has not complicated the procedure — in fact, we have noted a marked decrease in postoperative urinary-tract infections.

Discussion

This surgical method for establishing postoperative drainage of the bladder offers several important advantages. Most significant, perhaps, is the reduction in incidence of urinary-tract infections. We agree with Hodgkinson and others who have found that prophylactic antibiotic therapy tends to predispose patients to drug-resistant chronic bacteriuria. With suprapubic cystostomy, the occasional infection can be treated specifically and, therefore, much more effectively.

Our morbidity rate with this technique has been markedly decreased in comparison with previous experience. Also, the incidence of vexing urinary problems is lower (dysuria, urgency, and frequency). Premature removal of the catheter is not a source of complications because patients can, if necessary, be sent home with the catheter in place, to be checked and removed as an office procedure later on.

Nursing care is much improved. Patients are no longer at the mercy of inadequately trained attendants, because they learn how to open and close the catheters themselves and to check for residual urine, without depending upon nursing attendants. As a result patients are more comfortable, anxiety is eliminated and their outlook more cheerful. Nurses, too, are happier, since their work load is lightened and while at the same time, they need not feel guilt that they may be overlooking bladder dysfunction.

It seems likely that a simple method of suprapubic cystostomy is the technique of choice where bladder drainage is necessary following gynecologic operations.

References

1. Andriole, V. T.; Kunin, C. M.; Stamey, T. A.; and Martin, C. M.: Preventing Catheter-Induced Urinary Tract Infections. *Hosp. Pract.,* Feb., 1968, p. 61.
2. Hodgkinson, C. P. and Hodari, A. A.: Trocar Suprapubic Cystostomy for Postoperative Bladder Drainage in the Female. *Am. J. Obst. Gynec.* 96: 773, 1966.
3. Shumaker, Edward: Personal Communication.



MONTHLY SURVEILLANCE REPORT
CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
FOR THE FOUR-WEEK PERIOD ENDING FEBRUARY 28, 1969

	1969 This 4-Week Period	1968 Same 4-Week Period	1969 Total To Above Date	1968 Total Same Date	Total Cases for 1968
Measles	38	39	50	70	352
Whooping Cough	15	42	19	85	429
Diphtheria	0	0	0	0	0
Mumps	612	2,282	978	4,136	14,655
Scarlet Fever & Strep Sore Throat	1,080	1,303	1,998	2,375	10,101
Tetanus	1	0	1	0	5
Poliomyelitis (Paralytic)	0	0	0	0	3
Hepatitis	271	141	484	289	2,356
Salmonellosis (Other than S. typhi)	30	45	67	85	614
Typhoid Fever (S. typhi)	0	0	0	0	1
Shigellosis	29	17	63	31	346
Aseptic Meningitis	11	3	18	8	265
Encephalitis	3	10	13	17	114
Meningococcic Meningitis	3	9	25	23	94
H. Influenzal Meningitis	5	7	7	10	64
Tuberculosis	189	234	395	515	2,647
Syphilis	371	462	808	1,045	5,351
Gonorrhea	1,328	1,192	2,937	2,975	18,153

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

Rhabdomyosarcoma: Report of 20 Cases

BY LAWRENCE S. BIZER, M.D.
DETROIT

Rhabdomyosarcomas are highly malignant tumors of skeletal muscle with low five year survival rates varying from 5 to 35%.[1, 2] The treatment of the primary lesion is surgical with or without the addition of radiotherapy. Unfortunately, the chances of long term survival of patients with rhabdomyosarcomas are frequently reduced by the absence of a planned and logical approach to the lesion.

"The best chance of curing the malignant tumors of the soft tissues lies in the hands of the therapist who makes the first attempt."[1] This warning by Stout is amply confirmed in a recent review of the medical literature pertaining to rhabdomyosarcomas and draws attention to the wide discrepancy in rates of local recurrence and survival, factors influencing prognosis, and problems in deciding the initial type and extent of surgical excision.[2] In an attempt to appraise our own past results and evolve a rational plan of therapy we have reviewed patients with rhabdomyosarcomas seen at the affiliated hospitals at Wayne State University from 1947 to 1968.

The 20 patients seen with rhabdomyosarcomas ranged in age from 2 to 76 years (**Table 1**). Eleven were males and nine were females. A microscopic diagnosis of rhabdomyosarcoma was confirmed in all patients by biopsy, microscopic examination of a resected specimen, or at necropsy. In general, embryonal rhabdomyosarcomas constitute about 60% of these tumors and most frequently occur in children or adolescents in the head and neck region.[3] Only four patients in this series were under 20 years of age and the normal preponderance of embryonal rhabdomyosarcomas is, consequently, not present. Sixteen of the tumors were of pleomorphic type, two were embryonal, and the remaining two were given no microscopic classification.

The tumors were widely distributed in anatomic locations: five on the head or neck; nine on the extremities; and six involving the trunk musculature and/or viscera. This is a customary distribution in series of rhabdomyosarcomas that are predominantly pleomorphic in type.

Treatment and the results of therapy are tabulated in Table 1. Six patients had local resection of their tumor and five are dead one month to nine years following treatment. One patient (W. B.) is alive 15 months following local resection of a pleomorphic rhabdomyosarcoma of the calf without recurrence as yet. Seven patients had radical excision of their tumor but in only one patient was this combined with an in-continuity node dissection. Five are dead 5 months to 4½ years following treatment. One patient (R. B.) is alive, without recurrence nine months following radical excision of a pleomorphic rhabdomyosarcoma of the thigh. A second patient (G. M.) died 16 years following radical excision of a pleomorphic rhabdomyosarcoma of the posterior neck without known recurrence. The remaining seven patients either refused treatment or were not treated surgically and all are dead. Thus, one patient in 20 (5%) is known to have survived more than 5 years following a pathologic diagnosis of rhabdomyosarcoma.

Six patients were treated with radiotherapy. In 5 of these patients radiotherapy was used following incomplete surgical excision, local recurrence or development of distant metastases. In one patient it was used as initial therapy. In only two cases could the total dosage be determined and it was inadequate in both. Two patients showed regression of tumor for 6 months and 1 year respectively, and in both instances radiotherapy was combined with systemic Dactinomycin.

Eight patients were treated with chemotherapy (Dactinomycin, Methotrexate, Vincristine) sometime during the course of their disease. Two of these patients showed tumor regression and both had been treated with a combination of radiotherapy and Dactinomycin as mentioned above.

Discussion

The great majority of surgeons see relatively few soft tissue sarcomas in a lifetime of practice. Their problem is further compounded by the fact that most rhabdomyosarcomas present as painless soft

Doctor Bizer is affiliated with the Department of Surgery, Wayne State University School of Medicine, Detroit General Hospital and the Darling Memorial Center, Detroit, Michigan and Veterans Administration Hospital, Allen Park, Michigan.

tissue masses that appear to be encapsulated and can be shelled out in an "easy" operation.

However, these tumors are never encapsulated but, instead, are invasive neoplasms with a pseudocapsule. When a pathologic report of malignancy is received, lymph and vascular channels have been opened by excisional biopsy and a further wide excision, while obviously necessary, may be an exercise in futility. For these lesions, it is vital that a logical plan of action be formulated whenever the surgeon is faced with the possibility that a soft tissue mass may be sarcomatous.

If laboratory and radiologic studies indicate that distant metastases are not present, the patient should be taken to the operating room and under tourniquet control, if possible, incisional biopsy accomplished under general anesthesia. A frozen section examination is done and if a microscopic diagnosis of sarcoma or rhabdomyosarcoma is confirmed, the definitive operative procedure is completed immediately. If the microscopic diagnosis is in question, the permanent paraffin sections are awaited prior to institution of definitive therapy.

Ten to 20% of rhabdomyosarcomas present with metastatic disease involving the regional nodes draining the area of the primary neoplasm. Radical surgical excision with en bloc excision of the regional lymph nodes, when feasible, is therefore the treatment of choice.[2, 4, 5, 6, 8] The involved skeletal muscles should be excised from origin to insertion because rhabdomyosarcomas spread along

TABLE 1. SUMMARY OF RHABDOMYOSARCOMA AT WAYNE STATE UNIVERSITY

Patient	Age At Diagnosis	Sex	Microscopic Diagnosis	Site	Treatment	Results
1. B. T.	76	M	Rhabdomyosarcoma	Spermatic cord	Orchiectomy 7/61	Metastases. Died 6/63
2. V. R.	68	F	Pleomorphic Rhabdomyosarcoma	Forearm	Below shoulder amputation 12/64. Right axillary dissection 1/65 (4 of 18 nodes positive).	Died 4/65. No autopsy.
3. W. B.	62	F	Pleomorphic Rhabdomyosarcoma	Calf	Local resection 4/67	Alive 7/68 No recurrence.
4. C. Z.	17	F	Pleomorphic Rhabdomyosarcoma	Neck	Hemimandibulectomy and neck dissection 3/64. Local recurrence 5/67, 11/67 and 4/68. Response to dactinomycin and radiotherapy. Pulmonary metastases 6/68.	Died 8/68 No autopsy.
5. E. W.	14	F	Pleomorphic Rhabdomyosarcoma	Chest wall and lungs.	None 7/61.	Died 9/61 Pulmonary metastases
6. R. B.	54	F	Pleomorphic Rhabdomyosarcoma	Thigh	Radical excision 10/67	Alive 7/68 No recurrence.
7. M. S.	70	M	Pleomorphic Rhabdomyosarcoma	Abdominal wall	Incomplete excision. Radiotherapy (2100 r) and methotrexate 3/63	Died 4/63 Metastases and local recurrence.
8. A. G.	28	F	Pleomorphic Rhabdomyosarcoma	Right lung	Liver metastases on admission. No treatment 11/57	Died 12/57 Metastases
9. G. M.	63	M	Pleomorphic Rhabdomyosarcoma	Posterior neck	Radical excision 4/50	Died 4/66 No known recurrence
10. R. H.	20	M	Pleomorphic Rhabdomyosarcoma	Right Masseter Muscle	Local excision 7/47. Local recurrence and pulmonary metastases 3/49 — reoperation.	Died postoperatively.
11. R. J.	36	M	Pleomorphic Rhabdomyosarcoma	Right thigh	Radical excision 5/58. Pulmonary metastases 2/60.	Died 11/61
12. P. C.	72	F	Pleomorphic Rhabdomyosarcoma	Right biceps	Biopsy 10/65. Severe basilar artery insufficiency	Died 12/65 of CVA. No autopsy
13. M. F.	40	M	Pleomorphic Rhabdomyosarcoma	Left knee	Biopsy 6/62. Refused treatment.	Alive with tumor 10/66. Lost to follow-up
14. J. J.	48	M	Pleomorphic	Right gluteus	Right hemipelvectomy 11/61. Local recurrence and lung metastases 10/64. No response to dactinomycin.	Died 4/65
15. W. C.	50	M	Pleomorphic Rhabdomyosarcoma	Right thigh	Local excision 4/65. Metastases to lungs and spine 3/66.	Died 5/66
16. P. H.	2	M	Embryonal Rhabdomyosarcoma	Left external ear	Radiotherapy (5000 r) and dactinomycin. Temporary regression 6/64. Lung metastases and local recurrence 1/65.	Died 6/65 Liver metastases
17. M. U.	9	M	Embryonal Rhabdomyosarcoma	Left eye	Orbital exenteration 9/63. Local recurrence 8/64, treated with radiotherapy and vincristine, no response. Brain metastases 11/65.	Died 3/66
18. J. D.	76	F	Rhabdomyosarcoma	Bladder and abdominal wall	Biopsy 12/65. Pelvic perfusion with dactinomycin	Died 2/66 Retroperitoneal hemorrhage. No metastases

the muscles of origin and occasionally are multicentric within the same muscle group. Amputation, disarticulation or quarterectomy will be required in many proximal limb lesions, recurrent lesions and in those tumors that are deeply adherent or diffusely invasive. With this approach, Pack and Eberhart reported a 33.8% five-year survival rate in 100 rhabdomyosarcomas of which 78 were extremity lesions.[8] The medical literature strongly suggests that the more radical the initial operative excision, the lower the local recurrence rate will be and the greater the ultimate five-year survival.[2]

Many rhabdomyosarcomas are radiosensitive and occasionally these lesions have been ablated with radiotherapy alone (6,000 r's or more).[9, 10, 11] In areas where radical en bloc excisions are impossible, operative treatment must be supplemented by radiotherapy. McNeer, et al, have recently recommended preoperative radiotherapy (3,000 - 4,000 r's in three to four weeks) for all soft tissue sarcomas.[9]

If distant metastases are present on initial examination, the primary lesion may either be excised or irradiated and the metastases treated with radiotherapy and chemotherapy. However, if a solitary pulmonary metastasis is present, the primary should be radically excised and the pulmonary lesion resected.[2, 8] Occasionally this course of action will result in prolonged survival. Recent reports have indicated a synergistic effect of combined treatment with radiotherapy and Dactinomycin.[12, 13] Objective regression of rhabdomyosarcomas treated with systemic Dactinomycin, Vincristine, or Cyclophosphamide are well documented in the literature, but the effect is usually of short duration.[14, 15] Regional perfusion of rhabdomyosarcomas may also produce objective tumor regression but without the addition of adequate operative resection has not produced cures.[16, 17]

Summary

The records of 20 patients with rhabdomyosarcomas seen at Wayne State University affiliated institutions between 1947 and 1968 are reported. Sixteen patients are dead and one died 16 years after initial therapy without known recurrence. Two patients are alive 9 and 15 months following initial therapy without recurrence. One patient was lost to follow-up more than 4 years following biopsy of a rhabdomyosarcoma. Results of treatment are poor and correspond to results obtained at most other institutions in this country during the past 25 years.[2] Improvement of results can be obtained if it is understood that rhabdomyosarcomas although often deceptively benign in appearance, are in fact highly malignant neoplasms and must be treated initially by radical operative excision, en bloc node dissection and, frequently, radiotherapy. The extent of the essential ablation may cause unavoidable deformity but the penalty of lesser procedures will frequently be the patient's death. A reasoned plan of management is outlined.

References

1. Stout, A. P.: "Tumors of the Soft Tissues," in Atlas of Tumor Pathology. A.F.I.P., Sect. II, Fasc. 5 Washington, D.C.
2. Bizer, L. S.: Review: Rhabdomyosarcoma. To be published.
3. Horn, R. C., Jr., and Enterline, H. T.: Rhabdomyosarcoma: Clinicopathologic study and classification of 39 cases. Cancer, 11:181, 1958.
4. Thorbjarnarson, B.: Sarcomata at the New York Hospital. Arch. Surg., 82:489, 1961.
5. Albores, Saavedra J.; Martin, R. G.; Smith, J. L., Jr.: Rhabdomyosarcoma: A study of 35 cases. Ann. Surg. 157:186, 1963.
6. Bardwil, J. M. and MacComb, W. S.: Sarcomas of the Head and Neck with Special Reference to Rhabdomyosarcoma. Am. J. Surg., 108:476, 1964.
7. Phelan, J. T.; Grace, J. T. and Moore, G. E.: Hemipelvectomy for the Management of Soft Tissue Tumors of the Lower Extremities. Am. J. Surg., 107:604, 1964.
8. Pack, G. T. and Eberhart, W. F.: Rhabdomyosarcoma of Skeletal Muscle: Report of 100 Cases. Surg., 32:1023, 1952.
9. McNeer, G. P.; Cartin, J.; Chu, F., and Nickson, J. J.: Effectiveness of Radiation Therapy in the Management of Sarcoma of the Soft Somatic Tissues. Cancer, 22:391, 1968.
10. Greer, C. H.: Rhabdomyosarcoma of the Head and Neck with Special Reference to the Orbit. Trans. Ophthal. Soc. Aust. 25:80, 1966.
11. Mahour, G. H.; Saule, E. H.; Mills, S. D. and Lynn, H. B.: Rhabdomyosarcoma in Infants and Children: A clinicopathologic study of 75 cases. J. Ped. Surg., 2:402, 1967.
12. Edland, R. W.: Embryonal Rhabdomyosarcoma. Am. J. Roent., 93:671, 1965.
13. Tan, C. T. C.; Dargeon, H. W., and Buchanel, J. H.: The Effect of Actinomycin D on Cancer in Childhood. Ped., 24:544, 1959.
14. Sutow, W. W.; Berry, D. H.; Haddy, T. D.; Sullivan, M. P.; Watkins, W. L., and Windmiller, J.: Vincristine Sulfate Therapy in Children with Metastic Soft Tissue Sarcoma. Ped. 38:465, 1966.
15. Pinkel, D., and Pickren, J.: Rhabdomyosarcoma. Surg., 52:585, 1962.
16. Krementz, E. T. and Shaver, J. O.: Behavior and Treatment of Soft Tissue Sarcomas. Ann. Surg., 157:770, 1963.
17. Krementz, E. T.: End Results in the Treatment of Sarcoma by Perfusion with Chemotherapeutic Agents. Cancer Chemotherapy Reports, 10:83, 1960.



SCIENTIFIC PAPERS

Scientific Articles Printed to Date

Each month *Michigan Medicine* prints selected outstanding scientific articles. To date, the following papers (with month, page number and author following) have been published:

JANUARY

Page 31, *"Lower Lung Field Tuberculosis,"* by Ma. Zenaida Fernandez, M.D., Zamboanga City, The Philippines, and Edward G. Nedwicki, M.D., Allen Park.

Page 36, *"Use of Cholesterol Kits,"* by Kenneth R. Wilcox, M.D., (Reprint from New England Journal of Medicine, Vol. 279, No. 18).

Page 37, *"Mammography and Xeroradiography,"* by John N. Wolfe, M.D., Detroit.

Page 39, *"Early Management of Facial Nerve Trauma,"* by Roger Boles, M.D., Ann Arbor.

Page 45, *"Treatment of Hypercalcemia,"* by Joseph J. Weiss, M.D., and Jose Yanez, M.D., both of Eloise.

Page 49, *"More Drugs Mean More Problems in Managing Diabetes Mellitus,"* by John B. Bryan, M.D., F.A.C.P., Royal Oak.

FEBRUARY

Page 119, *"The Future of Private Practice: Salvation at the Grassroots;"* by Lewis A. Miller, Stamford, Conn.

Page 131, *"Mouse Toxicity of Triple Vaccine (DTP) Mixed with Poliomyelitis Vaccine,"* R. Y. Gottshall, G. R. Anderson, E. A. Nelson and K. R. Wilcox, M.D., all of Lansing.

Page 135, *"Massive Intra-articular Injection of Methylprednisolone without Harmful Side Effect,"* by J. C. Breneman, M.D., Galesburg.

MARCH

Page 209, *"Myocardial Infarction During Hyperthyroidism,"* by Robert C. Douglass, M.D., Southfield; Myer Teitelbaum, M.D., Detroit, and Gerald J. Aben, M.D., Southfield.

Page 213, *"Trichophyton Violaceum,"* by James D. Stroud, M.D.; Jules Altman, M.D., and Coleman Mopper, M.D., all of Detroit.

Page 215, *"Psychiatric Referral of a Pediatric Patient,"* by Joan R. Chodorkoff, Ph.D., and Bernard Chodorkoff, M.D., Ph.D., both of Detroit.

Page 217, *"Development of a Program of Laryngoscopy, Therapeutic Bronchoscopy and Endobronchial Blocking Techniques: A Progress Report,"* by Martin L. Norton, M.D., F.A.C.C.P., Detroit.

Page 220, *"Accidental Poisoning, Where Do We Go From Here?"* by George M. Lowrey, M.D.

Page 221, *"Diabetes and Pregnancy — Preliminary Report,"* by Nancy T. Caputo, M.D., and Agna N. Pineda, M.D., both of Detroit.

Page 223, *"The Electrophoresis of Lipoproteins,"* by John G. Batsakis, M.D., and Martha M. Thiessen, B.S. (ASCP), both of Ann Arbor.

Psychiatric Referrals In A General Hospital

BY WIECHER H. VAN HOUTEN, M.D.
ANN ARBOR

In recent years, many hospitals have established, or are in the process of adding psychiatric services. This is in response to the growing awareness of the important and helpful roles psychiatry can play in the overall medical management of the patient. One aspect of these psychiatric services in a general hospital is the "psychiatric consultation."

The purpose of this paper is to study some aspects of psychiatric consultations. I will not go into a detailed examination of individual psychiatric referrals, but will limit myself to an examination of some numerical data pertaining to the relationship between psychiatry and the other clinical services in a general hospital. To know, for example, which clinical services most often use psychiatric consultations, or what disposition is most frequently used by a psychiatric consultant, will be of some help in planning and establishing a psychiatric service in a general hospital.

Method

Psychiatric consultations requested by the clinical services in the University of Michigan Medical Center are answered by the psychiatric outpatient department. The data reported in this paper cover a one-year period. The psychiatric referrals were separated as to their source of origin, e.g., outpatient or inpatient clinical services, and a distinction between emergency and routine psychiatric referrals was made.*

The psychiatric consultations were studied in relation to three different variables: (1) services that requested the psychiatric consultation; (2) the diagnosis, and (3) the disposition recommended by the psychiatric consultant.

Results

A total of 1,388 requests for psychiatric consultations from the other medical services were received by the psychiatric outpatient department during a one-year period. The data collected are presented in three tables. The first table (**Table 1**) shows the frequency of the different clinical services' requests for psychiatric consultations. Nearly half of the psychiatric consultations were made to the medicine services. A little more than 20% to neurology, orthopedics less than 10%.

The second table (**Table 2**) shows the diagnosis in relation to psychiatric referrals. Depression is entered under psychosis if it was diagnosed as a psychotic depression and under neurosis if the patient was diagnosed as suffering from a psycho-

The author is Assistant Professor of Psychiatry, Assistant Chief, Psychiatric Outpatient Clinic, University of Michigan Medical Center

* Psychiatric consultations are requested by a written note (refer sheet) on which the reason for the request is stated. Emergency consultations are marked as such by the referring source.

TABLE 1

Diagnosis	Inpatient				Outpatient					
	Routine	%	Emergency	%	Routine	%	Emergency	%	Total	%
Acute Brain Syndrome	36	5.39	1	4.76	6	0.94	3	4.83	46	3.31
Chronic Brain Syndrome	47	7.04	3	14.28	23	3.60	3	4.83	76	5.48
Psychosis	18	2.69	0	0	12	1.88	7	11.29	37	2.67
Schizophrenia	32	4.79	2	9.52	50	7.83	8	12.90	92	6.62
Psycho-Physiological Reaction	88	13.19	2	9.52	63	9.87	2	3.22	155	11.17
Psychoneurosis	229	34.33	6	28.57	240	37.61	18	29.03	493	35.52
Personality Disorder	150	22.48	6	28.57	184	28.84	15	24.19	355	25.58
Transient Situational Personality Disorder	35	5.24	1	4.76	20	3.13	4	6.45	60	4.32
Mental Retardation	5	0.74	0	0	10	1.56	1	1.61	16	1.15
No Mental Illness	27	4.04	0	0	30	4.70	1	1.61	58	4.18
TOTAL	667	100	21	100	638	100	62	100	1,388	100

TABLE 2

Source of Referral	Inpatient				Outpatient					
	Routine	%	Emergency	%	Routine	%	Emergency	%	Total	%
Medicine	260	38.98	6	29.57	302	47.33	20	32.26	588	42.36
Neurology	139	20.84	7	33.33	142	22.26	12	19.35	300	21.61
Orthopedics	67	10.04	1	4.76	47	7.37	3	4.84	118	8.50
Obstetrics-Gynecology	20	3.00	1	4.76	17	2.66	3	4.84	41	2.95
Surgery	44	6.60	2	9.52	7	1.10	0	0	53	3.82
Urology	29	4.35	1	4.76	12	1.88	0	0	42	3.02
Otology	8	1.20	0	0	17	2.66	1	1.61	26	1.87
Neurosurgery	15	2.25	0	0	4	0.63	2	3.22	21	1.51
Allergy	14	2.10	1	4.76	13	2.04	0	0	28	2.02
Others	71	10.64	2	9.52	77	12.07	21	33.87	171	12.75
TOTAL	667	100	21	100	638	100	62	100	1,388	100

TABLE 3

Types of Disposition	Inpatient				Outpatient					
	Routine	%	Emergency	%	Routine	%	Emergency	%	Total	%
Referring Clinic	382	57.27	10	47.61	194	30.21	10	16.12	596	42.93
Neuro-Psychiatric Institute Outpatient Department	32	4.79	1	4.76	98	15.36	13	20.96	144	10.37
Family Physician	51	7.64	2	9.52	81	12.69	4	6.45	138	9.94
Private Psychiatrist	80	11.99	2	9.52	92	14.42	10	16.12	184	13.25
Neuro-Psychiatric Institute	17	2.54	0	0	13	2.03	8	12.90	38	2.73
Other Psychiatric Hospital	13	1.94	2	9.52	12	1.88	6	9.67	33	2.37
Mental Health Clinic	58	8.69	3	14.28	99	15.51	7	11.29	167	12.03
Other	34	5.09	1	4.76	49	7.68	4	6.45	88	6.34
TOTAL	667	100	21	100	638	100	62	100	1,388	100

neurotic depression. As can be seen the diagnosis psycho-neurosis was most frequently used, followed by personality disorder and psycho-physiological reaction. For both in- and outpatient settings this distribution of the diagnosis is about the same.

A different pattern emerges if we look at the emergency psychiatric consultations. The outpatient clinics demanded about three times as many emergency psychiatric consultations than the inpatient services. The diagnosis most often encountered in inpatient psychiatric emergencies was chronic organic brain syndrome. In an outpatient setting the diagnosis psychosis was most frequently made.

Disposition recommended by the psychiatric consultants for the 1,388 psychiatric consultations are presented in table 3 (**Table 3**). In nearly half of the cases (43%) it was felt that the patient could be handled by the referring source (referring clinic). In these cases advice as to management and/or drug therapy was given by the psychiatric consultant. Mental health clinics, psychiatrists in private practice, family physicians, and our own psychiatric outpatient department were the next most common disposition for follow-up care.

Discussion

Psychiatric consultations are complex phenomena. Many factors play a part. The interaction between patient and physician is decisive as to the question whether a psychiatric consultation is indeed necessary. Psychiatric consultations have been described as "patient situations."[1] The breakdown of communication between the patient and the caring-for people on the ward often leads to psychiatric consultation, especially "emergency" psychiatric consultation.

This model of a breakdown in communication or non-communication between physician and patient might explain the more frequent occurrence of emergency psychiatric consultations in an outpatient clinic than in a comparable inpatient setting. In outpatient clinics, contact between the patient and physician is short. Many patients have to be seen, decisions have to be made immediately. On the one hand the patient might feel shortchanged by not getting enough "attention" from his physician and other staff. The physician on the other hand sometimes feels pressured to make a decision about a psychiatric condition for which he does not feel qualified.

These two factors can bring a breakdown in communication and lead to the request for an emergency psychiatric consultation. These same factors do of course also apply to an inpatient setting but the time factor is less critical. The patient is in the relatively "safe" surroundings of the hospital and the decision does not have to be made immediately because most of the time the patient is not going home in an hour or two. This will take some pressure off the attending physician

who then will feel more confident in asking for a routine psychiatric referral.

As far as the total number of psychiatric consultations is concerned, the medical services most frequently use the help of the psychiatrist. Relatively speaking, however, the neurology service is the one that uses the psychiatric consultant more frequently.** This can be explained by the historical relationship between neurology and psychiatry. Often a patient with psychological symptoms is seen first in a neurology clinic and then referred to a psychiatric clinic. And for many patients it is easier to accept hospitalization on a neurological service than being admitted to a hospital as a psychiatric patient.

The table about the disposition (**Table 3**) shows that most frequently it is felt by the psychiatric consultant that the referring clinic can continue to take care of the patient. Hospitalization is very seldom needed and is used in less than 5% of our total dispositions. From these data it becomes evident that psychiatric consultants can function in a general hospital even though there are no psychiatric beds as such in a given hospital. Most of the patients can be managed with the help of a psychiatrist on the ward.

**The neurology service is much smaller than the medicine service as far as bed occupancy, outpatient visits and staff personnel are concerned.

Summary

This is a study of psychiatric consultations in a general hospital. The focus is on some numerical data related to three different aspects of the psychiatric consultation. The relationship between the different medical services and the need for psychiatric consultation is examined. Also the diagnostic categories of and the disposition for the psychiatric consultations are discussed. Some comments are made about the relationship between routine and emergency psychiatric consultations.

References

1. Meyer, Eugene and M. Mendelson. "Psychiatric Consultations with Patients on Medical and Surgical Wards: Patterns and Processes." *Psychiatry*, 24: 197-220, 1961.

Longevity of Prominent Physicians Rated Sixth Among Who's Who Groups Studied

Prominent medical men, according to a study of the longevity of men listed in *Who's Who,* have a mortality rate 22 percent less than that among all white males in the general population.

Physicians between the ages of 45-64 who made it into the pages of that *Who's Who* had a mortality rate only two-thirds as high as physicians at all levels of accomplishment, according to the study.

But researchers Jules V. Quint and Bianca R. Cody of the Statistical Bureau of Metropolitan Life Insurance Co., New York City, ranked doctors only sixth in longevity among all the types of prominent men listed in the 1950-51 *Who's Who.* According to their 12-year follow-up of 6,329 distinguished professional and business men, the doctors registered a mortality rate as high as 20 percent greater than other men in the volume.

Researchers Quint and Cody found top businessmen in *Who's Who* the longest-lived, followed in order by educators, judges and lawyers, men of letters (authors, writers, critics, historians, editors, journalists and correspondents), church officials, physicians and surgeons, scientists, military men, government officials, engineers and artists.

"THE CAUSES OF DEATH among these outstanding men covered in the survey are not known," wrote authors Quint and Cody. "The data compiled, however, definitely do show that men at high levels of achievement in the professions or business world have a comparatively low mortality rate and have lived on the average distinctly longer than men in the general population.

Quint and Cody suggest there may be some connection between education and long life.

Investigators of 47-year-old former college "honor men" of the late 1800's and early 1900's made comments which are as relevant today as they were at that time, emphasized Quint and Cody.

SAID THE EARLY investigators, "Is this difference in mortality because mental and physical fitness tend to go together? Or is it because it is difficult for a man to excel in scholarship unless he is in good physical condition? Probably both these causes contribute to bringing about the observed effect."

Quint and Cody discovered that medical specialists showed a mortality 20 percent less than all male physicians and non-specialists recorded a mortality 10 percent above.

They also learned the 341 *Who's Who* physicians and surgeons at ages 45 and over registered a 10 percent greater mortality than the entire sampling of outstanding men. An earlier study of the mortality among physicians during the five-year period 1938-1942 found that at the beginning of their careers physicians had an expected lifetime about one quarter of a year more than white males in the general population. But from age 35 on, their probable span of life was slightly shorter than for all white males.

Jackson County Has Newest Heart Center

Jackson County residents with questions on high blood pressure, rheumatic fever, varicose veins, heart defects, coronary heart attacks and strokes now have a "Heartline" to dial for immediate answers.

The "Heartline" is the telephone number of the Jackson County Heart Unit's first Heart Information Center, officially opened in early February in donated quarters in Mercy Hospital's Blair Annex. Jackson County Medical Society member Robert W. Corley, M.D., is the president of the county heart unit and founder of the center.

The center's purpose, says Doctor Corley, is both preventive and for treatment for cardiac patients and their families. Forty volunteers will man the center, which will offer books, pamphlets and movies on heart disease and related diseases. Volunteers will act as an emergency referral service and will answer questions concerning memorial funds. In the future they will supply transportation for tests and treatment and operate a speaker's bureau.

Many of the centers also promote local programs such as heart forums and sponsor cardio-pulmonary resuscitation classes, and classes for victims of heart disease or stroke to help them readjust to daily life. The Michigan Heart Association's program of information centers is one of the first of its kind in the nation and has been used as a model by several other states.

The Sinai Hospital Low Vision Clinic

BY MORRIS J. MINTZ, M.D.
ERNEST M. GAYNES, O.D.
ARNOLD H. GORDON, O.D.
ALL OF DETROIT

The importance of visual improvement to the partially sighted is reflected in the statistics regarding the blind and partially sighted in the State of Michigan. There are 16,000 totally blind, but there are 24,000 partially sighted. It is for the latter group that low vision clinics have been developed.

The Sinai Hospital Low Vision Clinic developed because several members of the Ophthalmology Department had an interest in amblyopia (physiologic blindness). The clinic formally opened July 1, 1961, aided by a grant from the Office of Rehabilitation, Department of Health, Education and Welfare. Patients are accepted only by referral from either an ophthalmologist, an optometrist, or a social service agency whose patient has already been certified as legally blind. A person is declared legally blind if he has not better than 20/200 visual acuity in the better eye corrected with glasses, or not more than 20 degree visual field. Corrected visual acuity no more than 20/70 in the better eye is considered partial sight.

Any ophthalmologist can extend his routine eye examination and refraction to include the fitting of a reading aid. But he is usually too busy to devote the extra time needed to help the patient use the aid properly, or to counsel him in his problems which may stem both from his visual difficulties and from his relative blindness.

Treatment of the partially sighted patient is one of the less rewarding phases of ophthalmological practice. However, enough cases can be helped dramatically to warrant continued efforts to make visual aids available.

Improvement of visual acuity with optical aids is only one phase of therapy in patients with low vision. More important is consideration for the total patient, physically, mentally, socially, and economically. It is in this area that social workers, optical technicians, and mobility instructors (who teach a blind person to walk from place to place in the home and streets using a cane or other help) can perform their most useful services. The patient may have to learn that more than one visual aid is necessary, depending on his visual task. He may have to be encouraged to use his other senses, chiefly hearing and touch, to fuller advantage. He may be depressed because he cannot see or he may crave dependency on another person, preferring that someone lead him when he walks, read to him, and help him dress. He must be taught that he is able to be fully independent in every facet of life, both social and economic. The ophthalmologist can be called upon for his professional backing when this is needed.

Diagnosis

A careful history is taken to determine the approximate date of onset of decreased vision, when and where the vision loss is most apparent, and what tasks cause the most difficulty. The ophthalmologist also attempts to discover background material that might help him develop a schedule of therapy.

Diagnostic examination and evaluation is done by an ophthalmologist who then recommends appropriate medical or surgical therapy. Unfortunately, some conditions are not amenable to either medical or surgical treatment; in these cases paramedical personnel can be of service.

The basis of all low vision aids is magnification of the object as it is brought closer to the eye. This is accomplished with convex lenses, microscopes or telescopes. The partially sighted patient probably does not see the printed word as a person with normal sight does. The symbols are there, but they are seen in an entirely different, distorted form. These distorted letters can be interpreted into meaningful words.

When loss of vision is sudden, waiting is advisable before a reading lens is prescribed because the patient mourns his vision loss and will not accept less than a complete cure. When decrease in visual acuity is gradual, as in macular degeneration, a gradual increase in the reading correction will forestall any period of not reading. It is often

Doctor Mintz is Attending Physician on the Active Staff, Division of Ophthalmology, Sinai Hospital of Detroit and is also a Clinical Instructor at Wayne State University School of Medicine. Doctor Gaynes and Doctor Gordon are on the Paramedical Staff, Division of Optometry, Sinai Hospital of Detroit.

preferable to give such patients increased correction in the reading prescription only.

Visual acuity is measured at 10 feet, even less if necessary. Special acuity charts are used giving gradations not found on the usual Snellen chart. Keeler and Designs for Vision furnish two types of special charts. Picture charts and "E" charts are valuable because many patients are young and/or retarded. Acuity is measured as 10/80, 10/100, 5/400 as determined. Each eye is tested separately, with or without glasses that the patient may have had prescribed previously. No attempt is made to have the patient keep his head straight or erect. He is permitted to turn and squint.

A test for near vision is then carried out at 14 inches with and without glasses. The Keeler and Sloan reading cards are best for this purpose. For the illiterate an "E" chart may be used, and a special card is available showing the "E" in various sizes within a window. The symbol points in various directions as the wheel is turned.

Physical examination of the eye is done. Mydriasis (pupil dilatation) or cycloplegia (relaxation of the ciliary body and pupil dilatation) is used according to the age of the patient and when not contraindicated as in glaucoma. A retinoscopy follows unless it is not possible because of cloudy media or pinhole pupil. Then the refraction is adjusted subjectively always at 10 feet. Correction for near vision is then determined. A useful ratio is $D = \frac{1}{VA}$. D = dioptric value needed for near vision. Thus if corrected visual acuity for distance is 10/100, D = 10 and 10 diopters would be needed for correction of the near vision. A young child can easily accommodate this much and may not need an addition, whereas a presbyope will need a full addition. Where the near addition is high it is advisable to use only one eye for reading.

The proper correction is placed in the trial frame and the other eye is occluded. Well illuminated reading material is placed at the patient's nose at the trial frame and gradually moved away so he becomes aware that his focal distance is very short.

Trial reading instruction is given with loose lenses in trial frames or with special glasses with various dioptric strengths. Often the patient prefers greater magnification with a resultant loss of visual field. Following home trial, the advantages of weaker magnification and larger visual field can be explained.

When the fovea, with which we read, is destroyed, the patient must use eccentric viewing. Some patients discover this by themselves, at least for general vision. Others have to be taught, which takes time and patience. One begins with a simple explanation of the problem involved and how it can be solved by looking above, below, or to the side of the objects. The principle of eccentric viewing can be applied for both distant and near viewing.

Reading lenses which are readily available are Aolite microscopic lenses, full diameter microscopic lenses, and Volk conoid lenses. When eccentric viewing is used, only the largest diameter lenses should be prescribed. Nystagmus and head tilt require the largest diameter lens. Plastic lenses are preferred because glass lenses are heavy, though Volk conoid lenses are very good. These should be prescribed only if the patient is able to evaluate their superiority to other lenses. High cylinder lenses, those over 2.5 D, require the type of lenses which can be ground to that degree.

An attempt is then made to find the proper visual aid for seeing at a distance. The 2.5x monocular (Selsi) can be clipped onto the glasses and focused. This is valuable in classroom boardwork and is prescribed for both children and adults. The newest models have a reading cap that can be used as a telescopic device for near vision.

The Kestenbaum method of using a 50 mm+ 3.00 D sphere in aphakia is demonstrated. The lens is held at 12 to 20 inches in front of the eye and slowly moved forward and backward until the image is sharpest. The lens may be tilted if necessary and the best image is obtained looking through the top of the lens.

After initial examination and instruction, the patient is referred to the paramedical personnel referred to earlier for rehabilitation of reading activity.

Treatment of Special Age Group

Children up to early teens rarely need an addition for near reading because of their strong accommodation. Whether to give a reading addition is determined by the length of time the individual reads without fatigue. The patient in his mid-teens should be encouraged to get a reading addition to forestall the symptoms of easy fatiguability. This addition should be increased as the patient gets older.

Patients over 45 years old should be given the weakest addition with which they can read newsprint, thus keeping the visual field larger and the reading distance longer.

Case Reports

Case I

Alan C. first came to the clinic as a college student 18 years old. He wore an aphakic correction, which is a lens used after cataract extraction. His

best visual acuity was right 20/20, left 20/200. He had had cataract surgery of both eyes at age two or three. He was able to read well with the right eye, not at all with the left eye. Pleoptic treatment, an intensive stimulation of the fovea, had been instituted for the left eye and he was able to read with it, although not as well as with the right eye. Treatment was then stopped. At age 22 a retinal detachment occurred in the right eye. The eye became blind. The patient had planned postgraduate study so we instituted an intensive course of treatment to make him use his left eye for reading. He was able to read very well in the clinic (about one-half his previous speed), but claimed his light at home was not good. We became aware at this time of the acute anxiety state of the parents. This had influenced his poor visual performance at home. Suddenly he had a detachment in the left eye also, and his remaining vision gradually deteriorated so that he was totally blind. We immediately contacted the Metropolitan Society for the Blind, Inc. in Detroit and working with them the patient was given all the training needed for mobility and for returning to school. We did not permit him to sit around or be helped in any way by his parents or friends. He finally moved into his own apartment near school, enrolled in graduate classes, carried a full program, and scored all A's in his subjects.

This case illustrates that in spite of almost sudden blindness during a college career, there was only a relatively short period of time lost due to surgery and convalescence and the patient continued in his chosen field of a teacher in history.

Case II

A doctor who was the head of a large university biochemical department, because of failing vision, was no longer able to carry out all his functions without getting aid from his associates and had almost decided to quit working entirely. He was referred to the clinic. He was given several visual aids, each for a specific use. He has glasses for general wear. He also has glasses with a small telescope which he wears in the laboratory so that he can read thermometers at 36 inches.

He has a bifocal for short time near vision reading and he has full diameter microscopic lenses for prolonged near reading. When attending a lecture he carries a specially adapted 10 x 20 monocular (one eye) telescope so he can see charts and slides on the screen. He is carrying on his full duties and nobody seems to notice his "different" glasses.

Devices other than glasses can help the low vision patient. Adjustable easels are valuable and are used primarily to keep reading material erect. High intensity lamps are a source of relatively cool light which can be brought close to reading material. Limiting the visual field by means of pointers and aperture devices such as slit cut-out cards is helpful. Large print, 18 point type, is available in a few current magazines and newspapers, and in some textbooks.

Low vision patients have welcomed the availability of some of these special visual aids. The felt-tipped pen affords a wider stroke and larger script. Giant playing cards are commercially obtainable. Measuring tapes and rulers, micrometers, measuring spoons and cups are all available now, eliminating some problems with occupational placement of low vision patients. Controlled release medication vials and syringes are helpful to the diabetic in the administration of insulin.

Although treatment of the partially blind creates some special problems for ophthalmologists and paramedical personnel, the importance of servicing these patients is apparent. The Low Vision Clinic has seen a gradual increase in visits from 150 during the first year (1961) to 340 in 1967.

Conclusions

1. Partially sighted individuals can be greatly aided in improving their visual efficiency.
2. Intensive aid to these patients can help them physically, emotionally, socially, and economically.
3. A low vision clinic with its ancillary personnel can perform this job better than the individual practitioner.

Michigan Authors

J. G. Ravin, M.D., and **G. P. Hodge,** Ann Arbor, "Hypertrichosis Portrayed in Art," *Journal of the American Medical Association,* Jan. 20, 1969.

Richard C. Bates, M.D., Lansing, "The Fine Art of Medical Phonemanship," *Medical Economics,* Jan. 6, 1969.

Alexander Grinstein, M.D., Detroit, *On Sigmund Freud's Dreams* (book), Wayne State University Press, Dec. 31, 1968.

W. L. Howland, M.D., Bay City, "Now My Nurse Holds Office Hours, Too," p. 146, *Medical Economics,* Jan. 20, 1969.

Jan Schneider, M.D., Ann Arbor, "Virus Disease in Pregnancy," page 98, *The Nebraska State Medical Journal,* February, 1969.

Richard C. Bates, M.D., Lansing, "The Fine Art of Heading Off House Calls," p. 270, *Medical Economics,* Feb. 3, 1969.

Robert E. Mack, M.D., Detroit, "Complexities of Health Care Require Full-Time Chief of Service," p. 65, *Hospitals,* Feb. 16, 1969.

Charles M. Wylie, M.D., F.A.P.H.A., Ann Arbor, "A Selected Public Health Bibliography With Annotations," *American Journal of Public Health,* January, 1969.

Melvin L. Selzer, M.D., Ann Arbor, "Alcoholism, Mental Illness, and Stress in 96 Drivers Causing Fatal Accidents," *Behavioral Sciences,* January, 1969.

Sue Stableford, A.B., Johan W. Eliot, M.D., and **Leslie Corsa, Jr., M.D.,** Ann Arbor, "Family Planning Policies and Activities of State Health and Welfare Departments," page 127, *Public Health Reports,* February, 1969.

A. C. Kerlikowske, M.D., Ann Arbor, "The Future Role of Hospitals. . . ," page 4, *Michigan Hospitals,* February, 1969.

R. G. Rice, M.D., Lansing, "Emergency Health Care," *Challenge,* December, 1968.

D. E. Bledsoe, Midland, "Our Slipping Image," *Massacusetts Physician,* December, 1968.

Charles Innis, M.D., R. E. Pearson, RPh, and F. J. Salter, RPh, Ann Arbor, "Lidocaine vs Parabens as Convulsants," *Journal of the American Medical Association,* Dec. 16, 1968.

Johan W. Eliot, M.D., Ann Arbor, "Family Planning Activities of Official Health and Welfare Agencies, United States, 1966," *American Journal of Public Health,* April, 1968.

Maurice H. Seevers, M.D., Ph.D., Ann Arbor, "Psychopharmacological Elements of Drug Dependence," *Journal of the American Medical Association,* Nov. 4, 1968.

A. B. Varley, M.D., Kalamazoo, "The Generic Inequivalence of Drugs," *Journal of the American Medical Association,* Nov. 18, 1968.

W. H. Beierwaltes, M.D., L. M. Lieberman, M.D., V. A. Varma, M.D., and R. E. Counsell, Ph.D., all of Ann Arbor, "Visualizing Human Melanoma and Metastases," *Journal of the American Medical Association,* Sept. 30, 1968.

W. H. Janke, M.D., Flint, "Pulmonary Embolectomy," *Journal of the American Medical Association,* Sept. 30, 1968.

R. E. Buck, M.D., Ann Arbor, "Pyarthrosis of the Hip Complicating Chickenpox," *Journal of the American Medical Association,* Sept. 30, 1968.

Ray R. Eppert, Detroit, "Place of the Governing Board in Hospital Management," *Hospitals,* Dec. 1, 1968.

J. W. Ison, M.D., Bloomfield Hills, "Palpation of Dorsalis Pedis Pulse," *Journal of the American Medical Association,* Dec. 16, 1968.

J. R. Gosling, M.D., Ann Arbor, Review of "Surgical Pathology of Gynecologic Disease (Doughterty;" *Journal of the American Medical Association,* Dec. 16, 1968.

Winthrop N. Davey, M.D., Ann Arbor, "TB Control in the General Hospital," *Michigan Hospitals,* November, 1968.

The Physician and Differential Diagnosis Of Communicative Disorders in Children

BY GERALD S. LIGHT, M.D.
WILLIAM WOLSKI, Ph.D.
BOTH OF FLINT

Speech and language development may be particularly sensitive to reflecting various disorders in children, including mental retardation, hearing sensitivity loss, emotional problems and central language disorders or "aphasia." Although a differential diagnosis is sometimes difficult, an accurate diagnosis is critical in prescribing the proper treatment program and determining the probable prognosis. The complexities of effecting a differential diagnosis are illustrated by the case study cited below in some detail.

Case Report

W. B., a five-year-old white male, was seen initially for a routine pre-school examination. He was the product of a full term, uncomplicated pregnancy and delivery with a birthweight of six pounds, ten ounces. The neonatal period was unremarkable. Although he sat unsupported at six months of age, he did not walk unsupported until twenty months and he did not begin using words until two and one-half years.

There were no complaints at the time of the review. There had been no significant illnesses in the past and there was no family history of chronic or hereditary disease. The parents were separated, however, and the child was under the care of his mother. There is a history of nonfluent speech in a maternal aunt.

The physical examination revealed an alert, active child with no intelligible speech. The head circumference was 21¼ inches. The physical examination was unremarkable except for mild generalized instability. Vocalization patterns heard during the examination were gutteral, "grunting-like" sounds produced in an explosive manner. Language comprehension skills appeared more intact, however, and the patient followed relatively simple verbal commands.

Doctor Light is Staff Pediatrician and Doctor Wolski is Chief, Department of Speech and Hearing, C. S. Mott Foundation Children's Health Center, Flint.

The following laboratory tests were normal: CBC, urinalysis and urine ferric chloride. An electroencephalogram showed a mildly dysrhythmic pattern with no apparent localization. An audiogram revealed a mild hearing sensitivity loss bilaterally. An estimated intelligence quotient of 75 was obtained on a nonverbal scale. A psychiatric evaluation was noncontributory.

Discussion

Because the physician is frequently the first professional person to see a child with the presenting problem of delayed speech or language, he is in a particularly sensitive position to initiate and direct the proper treatment program. As noted above, a differential diagnosis may be difficult; however, it is imperative to establishing a proper treatment program and in determining the eventual prognosis.

Clinical experience suggests that a complete history and physical examination — including a neurological examination — may not be adequate for establishing a definitive diagnosis. The initial evaluation of the case cited above led to four possible diagnostic entities: (1) aphasia, (2) mental retardation, (3) emotional disorder, and (4) hearing loss. The presence of only a mild hearing sensitivity loss and the nonsignificant psychiatric evaluation eliminated two of the four major diagnostic possibilities. The psychologically determined intelligence quotient of 75 ruled out severe mental retardation as the basis for the delayed communicative skills. A gross neurologic lesion was ruled out by physical examination and electroencephalography, although in specific cases skull X-rays, pneumoencephalography and arteriography may be indicated.

On the basis of the findings cited above, it was decided to place the patient in an ongoing preschool speech and language stimulation program for further observation and study. This placement, supplemented by consultative observations and evaluations, led to a primary diagnosis of aphasia. More intensive study and observation will be

necessary, however, before a more definitive diagnosis can be made.

Aphasia may be defined as a partial or complete loss of the ability to speak or to comprehend spoken word due to injury, disease or maldevelopment of the brain.[1] Aphasic children are not uniform as a group, often being seen in referral centers for evaluation of mental retardation[2] or deafness.[3, 4] Common characteristics of aphasic children include severe speech disorders, language deficiencies, essentially normal nonlanguage functioning, male predominance, and usually normal electroencephalograms and audiograms. Treatment of this disorder is often complex and long term, requiring specialized facilities usually found in university or hospital speech and hearing departments or in special schools or classes.

Summary

As the physician in private practice is often the first to see the child with a speech and/or language disorder, he has the responsibility for diagnosing and prescribing the proper treatment. A case study has been cited to illustrate the complexities of making a differential diagnosis. In such instances the importance of functioning within the concept of "the whole child" cannot be overemphasized. A multidisciplinary approach to such problems, involving the pediatrician, psychiatrist, psychologist, speech pathologist, audiologist and social worker, may best serve to evaluate both the diagnostic and therapeutic possibilities.

References

1. Travis, L. E.: *Handbook of Speech Pathology*. New York: Appleton-Century-Crofts, Inc., 1957.
2. McIntire, Matilda, Wiley, J., and Wolski, W.: Central language disorders as seen in a mental retardation evaluation clinic. *J. Lancet*. 86: 374, 1966.
3. Goldstein, R., Landau, W., and Kleffner, F.: Neurologic observations on a population of deaf and aphasic children. *Ann. Otol.* 69: 756, 1960.
4. Goldstein, R., Landau, W., and Kleffner, F.: Neurologic assessment of some deaf and aphasic children. *Ann. Otol.* 67: 468, 1958.



HUTZEL HOSPITAL, second oldest in Detroit, is shown above as it appears today from Forest Avenue. The hospital, celebrating its centennial, was founded in 1869 in a weatherbeaten, five-room clapboard tenement on Cass near Montcalm. (See inset)

Hutzel Hospital Plans Centennial Observance

Medical leaders from throughout the nation are expected to take part in an observance June 5 marking the centennial year of Detroit's Hutzel Hospital, formerly Woman's Hospital.

The day will include a medical symposium, an open house for the public, and an employees' award dinner.

Mrs. Horace Prunk, a hospital trustee for 15 years, is general chairman and John N. Wolfe, M.D., is chairman of the Medical Committee for the centennial.

June 5 will also be the beginning of Hutzel Hospital Week in Detroit with the medical, surgical and hospital world joining the community in staging exhibits and other events to honor the institution.

A special guest at centennial functions will be Miss Eleonore Hutzel, first vice-president of the board of Trustees, in whose honor the hospital was named in 1965. Miss Hutzel has served the hospital 54 years in positions ranging from director of the Social Services Department – first of its kind in the city – to member of the Board and chairman of the Joint Conference Committee, a group comprised of trustees and physicians.

Physicians named to the Medical Committee for the centennial include Robert E. Mack, M.D., Bloomfield Hills, hospital director; John Reid Brown, M.D., Grosse Pointe; T. N. Evans, M.D., Detroit; Yoshikazu Morita, M.D., Detroit, and Thomas B. Stock, M.D., Southfield.

In its 100 years, Hutzel Hospital has grown from its beginning in a weather-beaten clapboard tenement house to its present 378-bed general facility which underwent extensive remodeling in 1966.

The second oldest hospital in Detroit (Harper Hospital is the oldest), Hutzel was incorporated June 5, 1869, as the Woman's Hospital and Foundlings' home for the purpose of "providing a shelter and hospital for expectant mothers and their children and for deserted babies, and to give them such physical, moral and spiritual aid as their needs required."

Hutzel was the first to have a Social Service Department in Detroit, the first in Michigan to have a laboratory for original research into women's diseases where researchers could investigate without cost, and one of the first in the country to have a mother's milk bureau for the collection and distribution of human milk.

It was a leader in the segregation of maternity patients from the medical and surgical patients, and currently is pioneering in the use of xeroradiographic process for the early detection of breast cancer.

Hutzel hospital was first opened to men in 1929. Today it serves the medical and surgical needs of men and women and employs more than 900 persons in addition to the medical staff, volunteers and students.

In 1968, Hutzel Hospital's Obstetrical Department became the only such facility in the new Detroit Medical Center, which includes Harper, Grace, Children's and Hutzel Hospitals and the Rehabilitation Institute.


It takes more than a pill
to lose weight

That's why Abbott's got what it takes–
a pill and a program for each patient

THE PRODUCT–5 Different Strengths

For smooth appetite control plus mood elevation

Desoxyn® Gradumet®

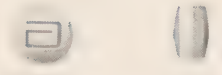
Methamphetamine Hydrochloride in Long-Release Dose Form



For patients who can't take plain amphetamine

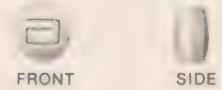
Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride, 60 mg. Sodium Pentobarbital



Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride, 90 mg. Sodium Pentobarbital



THE PROGRAM–3 Patient Booklets



Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably —and permanently. Food exchanges and a comprehensive list of foods, showing their calories, are also included.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

Compact new booklet features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

902110

ABBOTT

Please see Brief Summary on next page.

Ask Your Abbott Man For Patient Supplies.

BRIEF SUMMARY

Desoxyn® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates, or in those with history of manifest or latent porphyria.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Because of its sodium pentobarbital content, use Desbutal with caution in patients receiving coumarin anticoagulants. Pentobarbital may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

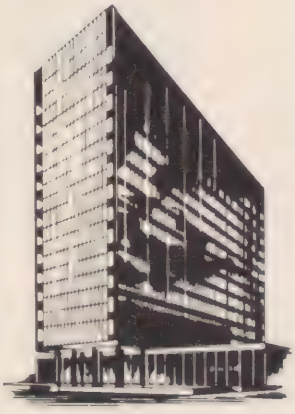
902110

ABBOTT



MSMS members may obtain copies of the AMA "Horizons Unlimited" career handbook with an eight-page Michigan insert by writing to MSMS, P.O. Box 152, East Lansing 48823.

Regional Medical Director
CHICAGO



An exciting position exists for a Physician in our Chicago Medical Office. Responsibilities involve establishing and monitoring clinical studies on investigational and marketed drugs in medical centers and establishing close liaison with leading hospitals.

Your background should include board eligibility. Preference will be given to applicants with prior experience in the pharmaceutical industry. Roche is noted for its growth and excellent reputation, salary, fringe benefits and opportunity. Varied interesting assignments as well as professional growth are outstanding.

Please address your confidential inquiry to:
Mr. R. H. Stevenson–Personnel Manager

ROCHE

HOFFMANN-LA ROCHE INC.
Nutley, New Jersey 07110
An Equal Opportunity Employer M/F

MSMS Members In the News

Harry A. Towsley, M.D., Ann Arbor,
has been elected to the board of directors of Media Medica, a New York-based firm producing multi-media courses of medical treatment for use by patients and physicians. Doctor Towsley is past president of the American Academy of Pediatrics and directs the Department of Postgraduate Medicine at the University of Michigan.

John A. Cowan, M.D., Lansing,
is assuming duties as medical director of a new health program for state employees with the Michigan Department of Civil Service. He retired Feb. 14 from his post as chief of the Division of Adult Health, Michigan Department of Health, after 23 years of service with the department. He has also resigned as a member of the Michigan Cancer Coordinating Committee, for which he served as a representative from The Michigan Department of Public Health.

Edward C. Dale, M.D., Newberry,
is new superintendent of Newberry State Hospital succeeding William H. Purmort, M.D., who retired in March. Doctor Dale was formerly clinical director at the Upper Peninsula state hospital and prior to that had for eight years been director of the Michigan State University Health Clinic.

Lino Romero, M.D., Birmingham,
a psychiatrist, is new director of Oakland County's $1.7 million community mental health program and has responsibility for all mental health services provided by the Oakland County Community Mental Health Services Board. Doctor Romero had been the program's acting director since August and prior to that had been assistant chief of medical school services at the Chicago Medical School.

Gerrit J. Kemme, M.D., Zeeland,
has been elected president of the West Michigan Academy of General Practice. Other new officers are J. Jay Post, M.D., Allendale, president-elect, and John A. Voss, M.D., Grand Rapids, vice president.

Harry E. Schneiter, M.D., Allegan,
has been elected chief of the medical staff of the Allegan Health Center. New vice-chief of the staff is A. P. Brachman, M.D.

INGRAM'S SERVICE DEPARTMENT

ALL FACTORY TRAINED MEN

We service Medical Equipment, Electrocardiographs, Basal Metabalors, Sterilizers, Autoclaves, Diathermy Outfits, Cutting Units, Ultra Violet Lamps, Hydro Therapy Units, Laboratory Equipment. ALL BURDICK, LIEBEL FLARSHEIM AND RITTER EQUIPMENT.

If you have any Service problems, please call us at TE 2-4444, ask for the SERVICE DEPARTMENT and we will gladly help in any way we can.

THE G. A. INGRAM COMPANY

4444 Woodward Avenue TEmple 2-4444 Detroit, Michigan 48201

ON SOLVING MANPOWER DILEMMA:

"We Should Embark On Aggressive Program"

BY JOHN W. MOSES, M.D.
SCIENTIFIC EDITOR

"The American Medical Association News" issue of February 24, 1969 devoted two full pages to Michigan's Medical Manpower shortage. The Michigan State Medical Society estimates the state will have a deficit of some 2,000 doctors at the start of 1969. Michigan's ratio of physicians is 123.5 per 100,000 residents compared to the national ratio of 141.5.

The Michigan State Medical Society organized a Citizens Committee on Medical Manpower to "spearhead a statewide effort to produce more doctors of medicine and other medical personnel."

One of the steps towards increasing the number of physicians is to increase the number of students in the medical schools and to expand Michigan State University's program to a four year program.

William N. Hubbard, Jr., M.D., Dean of the University of Michigan Medical School, is attempting to get funds to increase the entering class from 200 to 225 with the hope of eventually enlarging the entering class to 300 students. At present the first year class at Wayne State in Medicine is 130. Ernest Gardner, M.D., Dean, expects to have an entering class of 256 students by the time the Basic Science Building is completed in 1971 and also hopes to be graduating 300 students by 1974.

Higher Investment Necessary

The Dean of one of the schools recently stated that it costs the State of Michigan $11,000 per year, per student. If we increase our output of physicians by 300 per year we are obviously talking of an additional investment by the state, of better than $3,000,000.00 per year, not counting any costs for capital construction or building. This is indeed costly but the legislature must find means to fund this, as the need for more doctors is critical to the population of the State.

Since such a program is being promulgated to increase the Medical Manpower of the State of Michigan, first consideration should be given to students from the State of Michigan. It is quite likely that some means for financial assistance for students from the State may be necessary. One wonders how great a potential pool of doctors is being bypassed because the young men lack financial ability to pursue medicine as a career.

It might be possible for the State to grant loans to needy students to be repaid after training by a 10% forgiveness of the loan per year of practice in areas of need within the State.

Increasing the size of graduating classes is only one facet of the problem. In recent years between 40 and 50% of the graduating classes have gone to other areas of the country for their internship and residency training. Once gone they are not likely to return to practice in Michigan for various reasons.

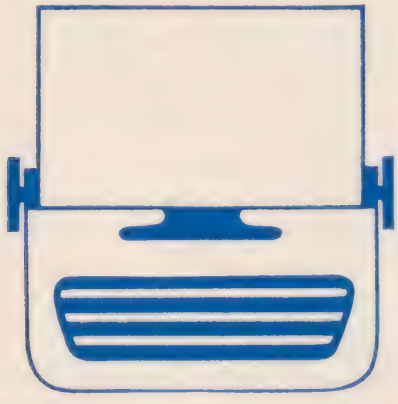
The universities cannot and should not attempt to be the only areas in intern and residency training. The majority of men in active community clinical care should seek their training in the environment of good teaching community hospitals. Unfortunately the majority of students have little access to such hospitals during their student years and therefore little knowledge of what such hospitals have to offer.

Utilize Community Hospitals

As part of the expansion of classes Michigan's three medical schools should be urged to use more community hospitals as clinical teaching areas during the clinical years. Most teaching hospitals today have one or more full time men involved in education and with such a program, most would be willing to add more full time men to the teaching faculty. I believe students would find a good teaching value in such a program. At the same time they would be better exposed to the community teaching hospitals in the State of Michigan, and hopefully, be more inclined to remain in the state.

Such a program would also be very advantageous to the schools from the viewpoint of increasing their clinical facilities and clinical faculty without increasing costs proportionately.

Unfortunately one of the problems accounting for the medical manpower shortage is maldistribution. Many areas in Michigan are begging for physicians and unable to obtain them. The problem is manifold. Through today's training, we end up with a very sophisticated product, a student who is used to the finer modalities such as image intensifiers, coronary care units, etc., as well as a way



EDITORIAL VIEWS

of life that does not require him to be on call 24 hours a day, seven days a week. To expect a man to go into a small community and give up the way he was trained is impractical. Areas in Michigan, such as Battle Creek, Kalamazoo, Traverse City, Petoskey — which have developed medical areas have no trouble acquiring doctors.

It is possible we should change our thoughts as to delivery of medical care in our less populated areas. It is possible we may have to develop regional medical complexes of 150-plus beds, rather than each community having its own 40-60 bed hospital. Certainly with our highway system, rapid ambulance service and even use of helicopters, such complexes can serve a large population.

Large Centers Better

By the use of a large center with the physician based either on the complex or close by, and modern communications, one could better serve the rural communities. Such complexes should be in a better position to attract men to work in a group atmosphere.

Another factor is our antiquated licensure set-up. At present our system, including basic science examination, tends to restrict admittance of men who are several years past medical school training. Passage of the single licensure act, now before the legislature, is a very necessary step forward.

Most of the proposals set forth above will not have results for the next five to 10 years.

But our needs are immediate — now!

Certainly the State of Michigan has much to offer. We are not, as many people think, a lunch-bucket community. Michigan is the seventh largest state in population, with the fifth largest city in the nation. Michigan has abundant medical capacity, with two excellent medical schools and high hopes for a third. It has excellent school facilities, sports programs, cultural achievements, theatre, hunting, fishing, skiing, outdoor life, scenic beauty, water sports, and most important, opportunity.

We should embark on an aggressive program of recruitment throughout the nation.

Suggests Ways To Stop Nuisance Malpractice Claims

The following is reprinted from the Editor's Page of the Detroit Medical News, March 3 issue. The author is John G. Slevin, M.D., Grosse Pointe Park.

One reason malpractice suits have greatly increased in the United States is that the plaintiff can start suit without paying his attorney unless the plaintiff wins his case. This peculiarly American legal arrangement, known as the contingent fee, means that the lawyer will use every legal device to win his case or get nothing for his efforts. It is defended by the majority of attorneys on the basis that otherwise the poor man would be denied his day in court.

It is noteworthy that in Canada, England and most other countries, the contingent fee concept is unethical. We are also informed that malpractice suits are at a minimum in Canada.

No doubt, at the time of its inception, the contingent fee concept had some merit. We wonder if, in our affluent society, it should not be reexamined. Why should anyone be allowed to start a suit without some show of financial responsibility? In Canada the plaintiff must post a bond with the court to cover the fees of the attorneys when the suit is filed. If he wins, the defense pays all costs. Otherwise, the plaintiff's bond is forfeited.

It is realized that most responsible legal firms will not accept a client's suit for malpractice until investigation proves that the client has good grounds to institute a suit. Unfortunately, some attorneys will start a suit and investigate only if the defendant is willing to fight it. They are aware that many insurance companies that underwrite professional liability insurance try to settle *any* claim, regardless of merit, out of court.

We know that pressure is brought to bear upon defendant physicians to agree to settlement out of court, even when there is no sound legal basis for the claim. We also know that this is one reason why professional liability insurance rates continue to soar. In Michigan the rates have just been increased fifty percent. The reason why insurance carriers seek out of court settlements of malpractice claims is that it is much cheaper for them to do so.

Hence, some lawyers can make a good living with little more effort than writing a letter to the defendant physician informing him that Mrs. X, his client, has filed suit for malpractice. The physician contacts his insurance agent who tells him "Don't worry doctor, we'll settle this claim without court action." If he agrees, the good doctor's next insurance premium (providing the company is willing to continue to cover him) will be substantially increased. This racket must be stopped!

One way to stop it, is for every physician who believes the malpractice claim is without merit, to insist, as is his right, to fight it in court.

Another way to stop the nuisance malpractice claim is for the American Bar to ban the contingent fee by making it unethical, except for the court determined indigent client. If the legal profession is not willing to do this, then the Bar should find a reliable method to prevent the exploitation of the medical profession through more stringent regulation of its members. Lawyers

(Continued on Page 369)



Hot
under
the collar...

high under
the cuff.

Sometimes
he forgets he has hypertension, gets hot
under the collar...high under the cuff.

For such
patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6392

should be required to show proof that a tort, with reasonable certainty, has been committed before filing suit for malpractice.

We believe that most attorneys and most physicians are honest. We believe that the culprits in both professions should pay for their faults. We hope our legal brethren will agree.

Flexible Retirement Best

BY A. HAZEN PRICE, M.D., CHAIRMAN
MSMS COMMITTEE ON AGING

The medical profession has done a great deal to help more people live longer, but unfortunately has not been as active in showing people how to live fuller lives.

Greater interest is necessary on the part of physicians to guide the community in its efforts to provide improved recreational, sociological and employment opportunities for those older people who need them.

One of the factors known to be responsible for much boredom and unhappiness in people 65 years of age and older is the fact that many who are still very alert and capable have been forced to retire simply because of an arbitrary age limit. To be sure, many have planned for an early retirement and have been looking forward to the time when they could live a life of relative inactivity. There are many more, however, who have known little more than work all of their lives who find themselves with no useful activity after retirement.

Physicians have recognized for years that mandatory retirement from one's life work on the basis of chronologic age alone tends to create many emotional and sociologic problems — as well as aggravate at times long-standing physical disability. Periods of anxiety and depression are common, leading oftentimes to disastrous results. Compulsory retirement without regard for the individual's desire and ability to continue work can be a prime factor in initiating the deterioration of the health of the retiree.

The MSMS and AMA have long urged that more consideration be given to expanding the opportunities for continued employment for those older persons who wish to remain in the work force past the compulsory retirement age. The Age Discrimination Act of 1967 was a significant step toward a fuller utilization of the skills of the growing number of people in the 40-65 year age group.

Retirement is bound to come sooner or later and it behooves everyone to make such plans as necessary so the transition from a life of activity to one of relative leisure is as smooth as possible.

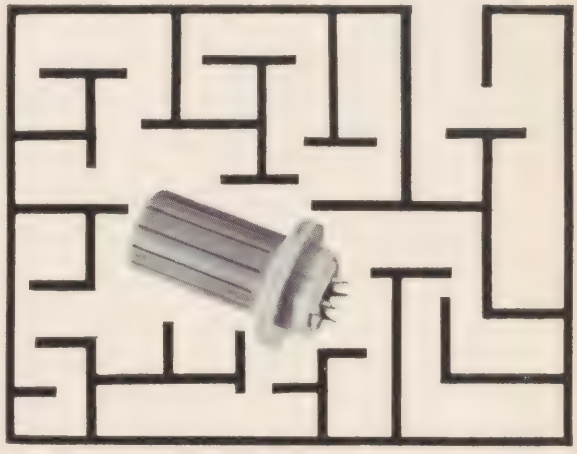
Perhaps industry has a responsibility towards its employees to initiate pre-retirement training programs during the last five years, at least, before the final break. During this time the company medical department could also play a significant role by providing counsel in the many aspects of preventive medicine.

While the question of mandatory versus flexible retirement is still a complex issue with pro and con advocates of each method, the weight of evidence favors the flexible plan. It is here that the medical, sociological and psychological factors have a much less disastrous effect upon the life of the older person for it encourages him to continue a productive and independent way of life.

About Mr. Finch

Writing on Robert H. Finch, Secretary of the U.S. Department of Health, Education and Welfare in the January 2 Washington, D.C. *Evening Star,* Judith Randal said:

"In California last year he backed a bond issue that, had it not been defeated at the polls, would have financed more medical and dental schools, but would not have stopped at just educating doctors, dentists and nurses. He firmly believes that in the interests of efficiency and economy, social workers, technicians, nursing aides and the like should be trained on the same campuses and have access to the same libraries, laboratories and facilities."



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9

Previous articles in this series have dealt with the definition of and need for utilization review. The most recent article explored the role of the non-physician; this article by a member of the professional staff of Blue Shield's Utilization Review Department, explores the role of the physician in this endeavor. The author is attending physician, Providence Hospital, Southfield and medical consultant to the Michigan Medical Service.

Louis F. Hayes, M.D.
Vice President
Medical Affairs Division

The Role of the Physician in Utilization Review

RICHARD A WAHL, M.D.
DETROIT

Since the inception of the practice of medicine, physicians have evaluated the quality of medical care. The medical school faculty not only teaches but examines the student. The attending staff members at our teaching hospitals not only instruct but also regulate the duties of the intern and the resident. Even after formal education has terminated, peer groups review the medical records of colleagues. Tissue Committees, Transfusion Committees, etc., are really parcels of utilization in general, the evaluation of medical services. Historically, we have a long precedent for physicians to evaluate the quality of medical services. This is firmly based in the fact that the physician, by virtue of his training, has the right to make medical judgments, but therein also has the responsibility to see that medical care is the best possible within the framework of our present knowledge.

But this responsibility has been exercised in only a small area of the health care field, the hospital. In addition, it has not had the impact it should on the economic factors. Now we are in a public spotlight that will shine brighter rather than diminish and many of the inadequacies in the health care field are being attributed, whether rightly or wrongly, to the physician. At the same time, the battle with disease is fought in an increasingly enlarging arena; the Extended Care Facility, the Office, and the Home. Likewise the scope has become more comprehensive and involves methods, instruments, and medications unheard of just a few years ago. Thus at a time when we must more than ever exercise our responsibility, the field of health care services seems enormous.

Should Exercise Responsibility

Yet, we must not abdicate our role as the authority on the quality of care. Should we not exercise this responsibility, the vacuum will surely be filled by others less knowledgeable, and perhaps even less sympathetic, to the time-honored physician/patient relationship. We should never leave the evaluation of medical services to those whose only credentials are the rhetoric of good intentions.

But the task of the physician regarding Utilization Review need not be formidable. We can use a combined approach to solve the problems of today, but of necessity must work with others, government or private enterprise, involved in the health care field. The non-physician can collect the raw data. Electronic data processing systems can simplify this work and patterns of usage of medical services can be interpreted in the light of medical judgment. The physician can and should remain the pivotal figure in a teamwork approach while using the modern technology that can give us the advantage of being able to have overview and detail simultaneously. Not to apply this methodology would certainly be a sad commentary on our attempts at efficiency when it is most necessary to conserve our time yet perform admirably.

Interpret Appropriate Usage

Thus, a workable solution is for physicians to review the data collected by modern technology and make the necessary recommendations as they see fit. With this approach, since the ultimate responsibility for the care of the patient rests with the physician, it is the physician who interprets what is appropriate usage of medical services. By allowing others to perform the non-medical tasks the physician's time will be conserved rather than encroached upon further.

Utilization Review is now actionable, not conceptual. It will allow physicians to be deeply involved in all aspects of the health services system. Unfortunately, men with years of distinguished service to the community speak out against a combined approach to Utilization Review. Our answer is in cooperation so the voice of the practicing physician is heard in a consistent fashion. The results should be a Utilization Review program professionally conducted that permits the physician to participate in fundamental decisions of major importance. This is the role we must assume to appropriately answer the imbalanced or misdirected criticism to which the medical profession is now subjected. This is the role we must assume so original intent and eventual outcome are synonymous. This is the role we must assume if we are to continue to assure quality medical care.

A "cold" fact



NTz® delivers relief of nasal symptoms

The *first spray*—1 or 2 squirts—of NTz opens the inferior part of the common meatus. The *second spray*, a few minutes later, shrinks the turbinates to promote adequate sinus drainage and ventilation—to help prevent sinusitis. Dosage may be repeated every three or four hours.

The fact is, NTz is more than a simple vasoconstrictor. It contains:

Neo-Synephrine® HCl 0.5%, a decongestant of unexcelled efficacy (in full adult strength) to shrink nasal membranes and allow comfortable breathing.

Thenfadil® HCl 0.1%, a topical antihistamine to help relieve itching and rhinorrhea.

Zephiran® Cl 1:5000, an excellent wetting agent and antiseptic preservative to aid rapid spread of components.

NTz, for temporary relief of nasal symptoms, is well tolerated, but overdosage should be avoided.

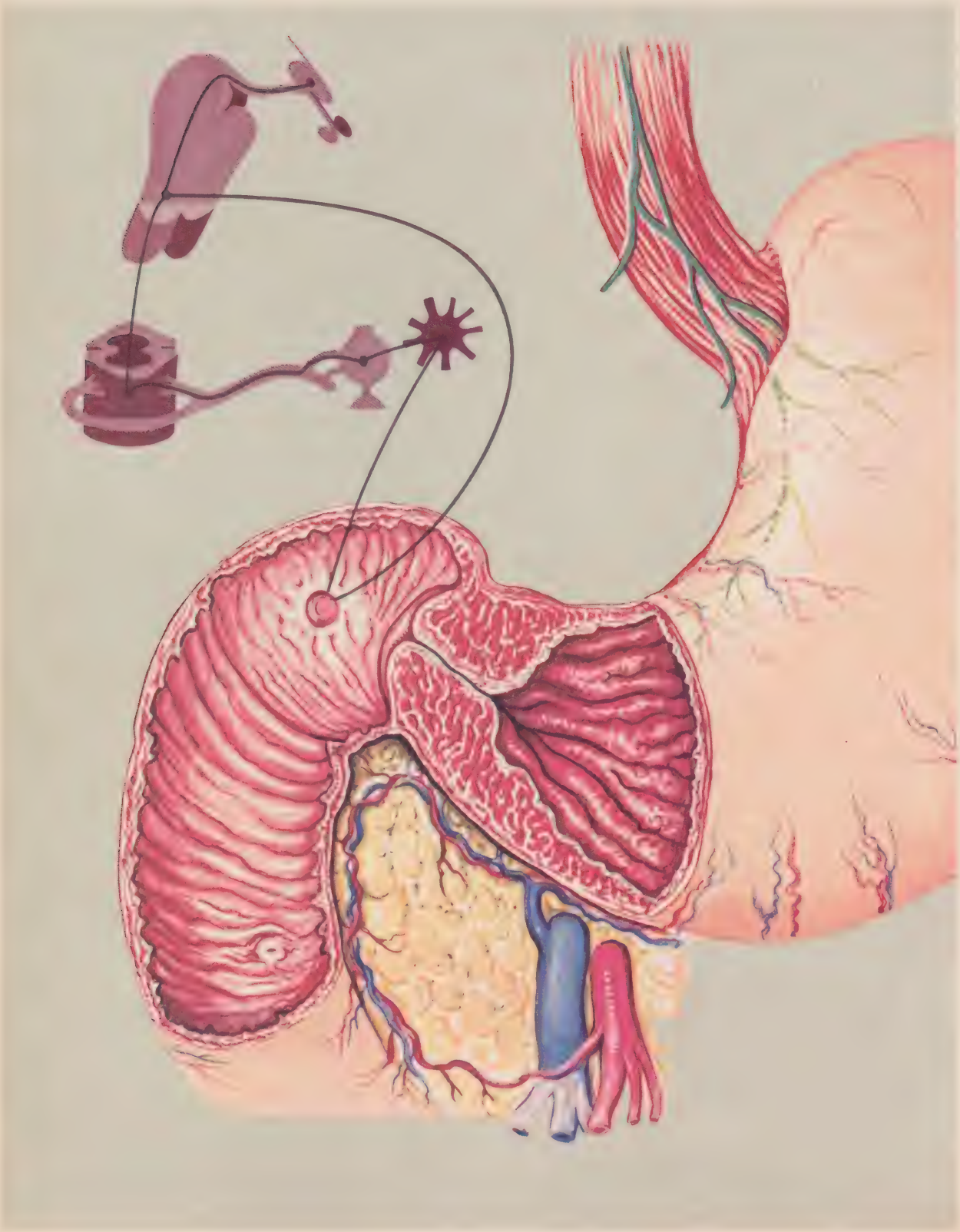
Available: NTz Nasal Spray in squeeze bottles of 20 ml.; NTz Solution in bottles of 1 oz. with dropper.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016

(12864)

Healing the ulcer crater



Pro-Banthīne®

brand of
propantheline bromide

blocks ulcerogenic autonomic impulses

Therapeutic Activity—Pro-Banthīne blocks ulcerogenic impulses at both parasympathetic effector sites and ganglia and at sympathetic ganglia.

This dual action, a capacity quite beyond that of belladonna derivatives, has been shown repeatedly to reduce gastric secretion, to suppress gastrointestinal motility and to relieve ulcer pain.

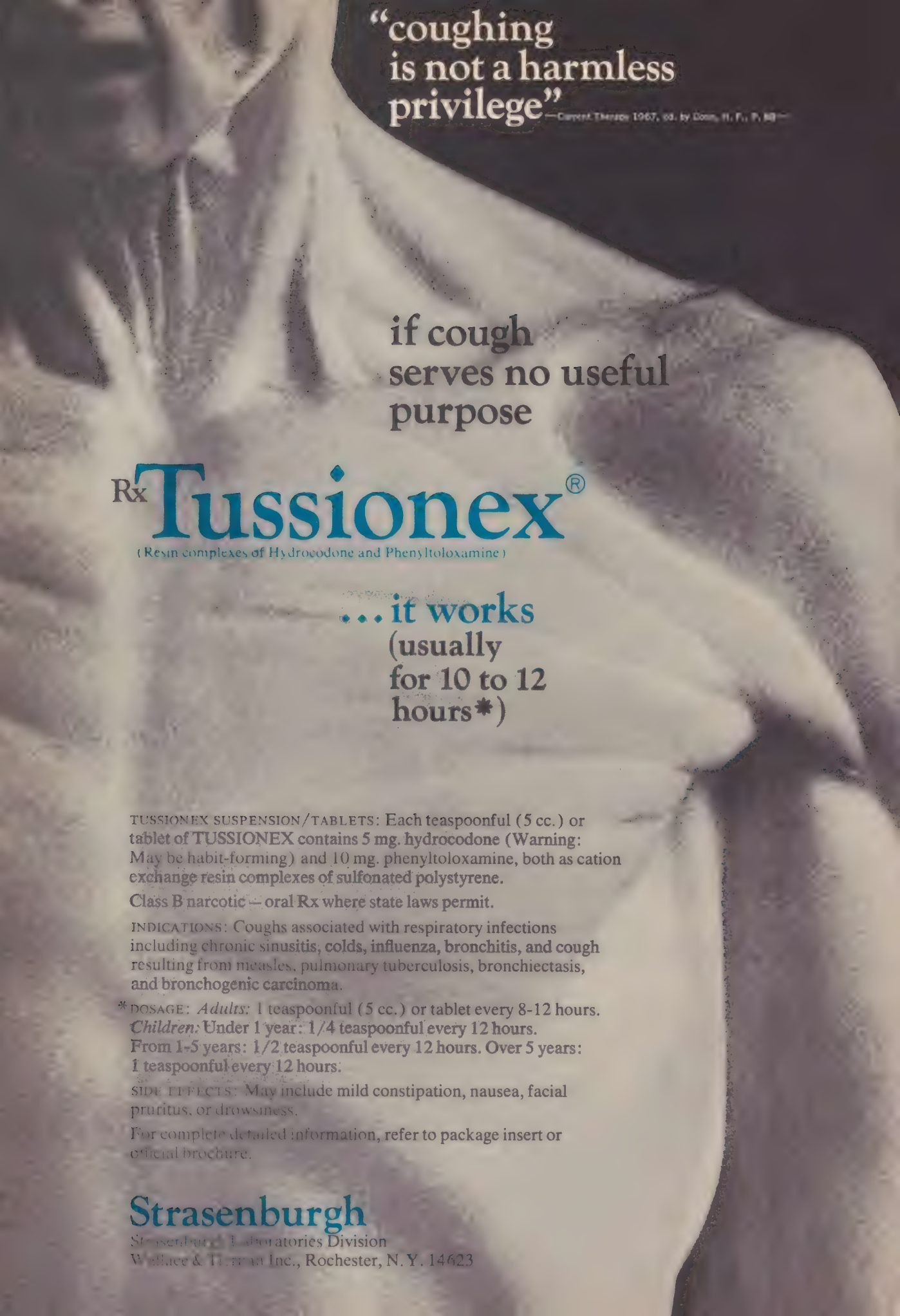
Healing Environment—Thus, Pro-Banthīne, together with other standard measures, creates a favorable environment to hasten healing of the ulcer.

So widely is this ability recognized that for years Pro-Banthīne has been the most widely prescribed medication for treating peptic ulcer.

Indications: Peptic ulcer, gastroenteritis, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.
Contraindications: Glaucoma, severe cardiac disease.
Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.
Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.
Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

981 4/69

SEARLE *Research in the Service of Medicine*



TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

* DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y. 14623





The Presidential Suite of Lansing's Jack Tar Hotel was the scene of the first public announcement of the introduction of the Single Medical Practice Act, supported by the Michigan State Medical Society. The bill was requested that day, Feb. 17, in the House and Senate.

Explaining the Single Medical Practice Act at the news conference were, in top photo from left, John J. Coury, M.D., Port Huron, member of The MSMS Council and of the Michigan State Board of Registration in Medicine; Ross V. Taylor, M.D., Jackson, chairman of The MSMS Council, and Frederick W. VanDuyne, M.D., Flint, also a member of the State Board.

Otto K. Engelke, M.D., chairman of the MSMS Committee on Legal Affairs, right, and Bud Vestal, Booth Newspapers, listened attentively to Proceedings (center photo).

The Capitol news corps was well represented (bottom photo). Among them were, from left, Jacqueline Korona, AP Lansing bureau; D. Curt Hanes, capitol bureau, Lansing State Journal; Barbara Cranham, UPI; Harry Boyes, Lansing bureau, Detroit radio station WJR, and Carl Olson, Michigan State University radio station WKAR.

SINGLE MEDICAL PRACTICE ACT 'MEETS THE PRESS'





Medical Center Progress Chart

1. *Children's Hospital (Under construction)*
2. ***Grace Hospital***
3. ***Harper Hospital***
4. *Hutzel Hospital*
5. ***Harper Residence***
6. *W.S.U. Research Building*
7. ***W.S.U. Basic Science Building (Under construction)***
8. *Children's Center (Under construction)*
9. ***Cathedral Terrace (Ground broken)***
10. *Medical Center Courts (Completed)*
11. *Professional Plaza (First two buildings completed)*
12. *Webber Memorial (Proposed)*
13. ***Cancer Foundation Research Center (Proposed site)***
14. *Luella Hannan Memorial Home (To begin in spring)*
15. *Harper Parking Facility (Under construction)*
16. ***Rehabilitation Institute***
17. *Harper Nurse's Residence*
18. *Grace Nurse's Residence*
19. ***Grace Hospital Wing (Proposed)***
20. *Out-Patient Clinic (Proposed)*
21. *Shiffman Library (Ground broken)*
22. ***Grace Parking (Proposed)***

Progress Report on the Detroit Medical Center

When the Detroit Medical Center is completed some time in the mid-1970's, an estimated $300 million of both public and private funds will have been invested in the 250-acre complex of hospitals, medical school facilities, professional services, businesses, schools, churches, and urban renawal projects.

Predicted for that same period is an annual payroll for the Center's "big four" hospitals — Children's, Grace, Harper and Hutzel — of between $40 to $50 million.

According to the Medical Center Citizens Committee, the Center will "attract new businesses to the area, create thousands of jobs, double the enrollment at Wayne's School of Medicine — while providing better medical education — improve the tax base for the city, and mean the complete revitalization of an area once almost written off as an unredeemable slum."

KEY IN ALL PLANNING is the general concept of the medical school and the hospitals at the core of the Center, surrounded by ancillary medical facilities, commercial and housing developments.

As the Center enters its 14th year, this is the summary of progress and the path ahead:

Children's Hospital — Ground was broken in August, 1967 for the first new hospital to be built in the Medical Center. The $24 million six-story structure, which is rising on an 11-acre area on Brush Street across from Harper, will house 320 beds and will have an attached 500-car garage.

Hutzel Hospital — Five million dollars was spent over a three-year period, ending in 1966, for building and remodelling projects. Hutzel now has new recovery rooms, eight operating rooms, an intensive care unit, a four-bed coronary care center, new X-ray facilities, an enlarged medical records department, and an extensive library.

Harper Hospital — The first hospital-owned staff residence in the Medical Center was completed in fall, 1966. The nine-story building, containing 143 apartments for medical staff members of Harper, as well as Grace and Children's, is located at the corner of Mack and Beaubien.

Research Building — The first of three buildings to be built within the Medical Center as part of Wayne's School of Medicine is located at Canfield and St. Antoine. Built at a cost of $4 million, the Research Building was opened in 1964.

THE TOTAL COST of Wayne's new medical campus is estimated at $56 million.

Basic Science Building — The nine-story building, when finished will provide 485,000 square feet of floor space. Begun in 1967 and scheduled for completion in 1971, the structure will cost an estimated $23.5 million.

The building, located at the southeast corner of Canfield and Brush, will house the administrative offices of the anatomy, physiology, pharmacology, biochemistry, microbiology, and pathology departments, as well as lecture rooms, research laboratories, study areas, television studio facilities, a kitchen and a cafeteria.

Shiffman Medical Library — Named for Abraham Shiffman, who donated the initial contribution for the building, the medical school library will cost $2 million. When finished, the three-level structure designed to contain 68-178 square feet, will house 160,000 books and provide accommodation for 800 persons. Ground was broken for the building Feb. 26.

Children's Center of Wayne County — Construction of this building for the treatment of disturbed children began in April. The $1-million, three-story center is rising at the northwest corner of Alexandrine and John R. It will provide space for 45 office-conference rooms and 10 group-therapy rooms.

Cathedral Terrace — Construction of this 16-story, six-sided, 210-apartment building, to be built around a central utility core, began this year.

Medical Center Courts — A $3.5 million federal grant was the initial impetus for seven, three-story, 230-unit apartment buildings, constructed by the Plymouth Housing Corporation, an affiliate of the Plymouth Congregational Church.

Professional Plaza — In 1962, while the four hospitals in the Medical Center were still in the early stages of planning their joint development, H. Fred Campbell, founder of the H. F. Campbell Company, an international construction company, envisioned the need for an office and commercial focal point for the whole medical development.

TWO MAJOR BUILDINGS are currently being designed for the Medical Center. The Webber Hospital, to be built between Grace and Harper hospitals, will provide increased teaching facilities and will accommodate 348 patients. Completion of the hospital will allow the university to double the size of the medical school, admitting 200 students annually.

The second large building being planned is the clinics structure which will be a part of the medical school. The architects, Smith, Hinchman and Grylls, are planning a building containing about 500,000 square feet of space, which will make it the largest structure in the Medical Center.

Described as the key building in the Center, the clinics will centralize out-patient, emergency and clinical services offered by all the Medical Center hospitals. The clinics, which will be used for teaching as well as treatment, also will provide care for residents in the Center.



CONGRATULATIONS: George T. Aitken, M.D., center, Medical Co-Director, Area Child Amputee Center, Grand Rapids, Michigan, is congratulated on his selection as president-elect of American Academy of Orthopaedic Surgeons at group's recent annual meeting in New York. With him, from left, are S. Benjamin Fowler, M.D., Nashville, Tenn., current president, and Charles H. Herndon, M.D., Cleveland, immediate past president.

RETIRING OFFICERS OF MDPAC were honored at the recent board meeting at MSMS Headquarters. In photo at right below, Vernon V. Bass, M.D., Saginaw, was presented with a gavel and engraved plaque bearing the inscription, "For His Dedicated and Outstanding Leadership as First Secretary-Treasurer and Retiring State Chairman." In photo at left below, George Anthony, M.D., Flint, received a pair of bookends engraved to honor his meritorious service as an officer. The bookends bear figures of a large fighting fish and a fisherman because Doctor Anthony is also retiring from practice. Presenting the awards on behalf of the entire MDPAC Board was Ralph Wills, MDPAC staff assistant.





CONSTRUCTION STARTED FOR MEDICAL LIBRARY AT WAYNE STATE

Another significant advance in State of Michigan medical facilities was observed with the groundbreaking ceremonies for Wayne State University's Vera Parshall Shiffman Medical Library February 26, in the Detroit Medical Center. Representing the third Wayne State building to rise in the medical complex, the $2,250,000 library is being financed through gifts and grants from the U.S. Public Health Service, from the Shiffman Foundation, and from WSU Medical Alumni.

The library will feature a reserve room open 24 hours a day, seven days a week, and teaching carrels, containing the latest in self-instruction equipment and electronically tied in to main campus computers to receive lectures.

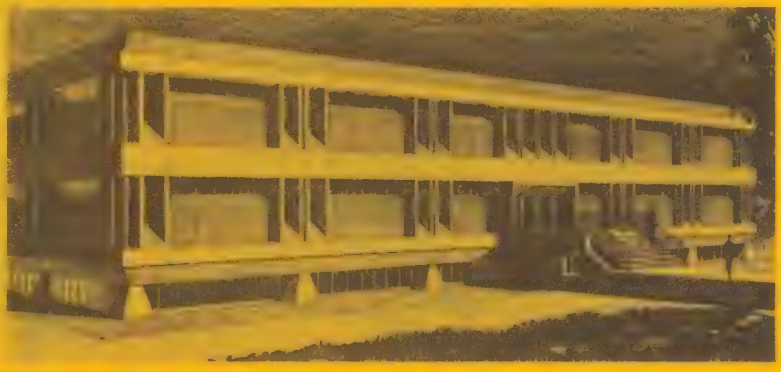
The library is expected to be completed in the Spring of 1970.

The Stapleton Room, named in honor of William J. Stapleton, Jr., M.D., past president of the Wayne County Medical Society and former associate dean of WSU's School of Medicine, will be located in the southwest corner of the second level. The walnut-paneled room will be furnished through gifts provided by the Wayne County Medical Society.

Abraham Shiffman, a life-long resident of Detroit and active in industrial real estate for many years, has made other major contributions to medicine in addition to his gift for the medical library.



ALFRED WHITTAKER, M.D., left and Alfred H. Sokolowski, M.D., right, both members of the WSU Board of Governors, join in groundbreaking ceremonies for the Shiffman Medical Library at Brush and Canfield in the Detroit Medical Center.



DESIGNED BY O'Dell, Hewlett and Luckenbach, Inc., architects, the primary function of the Vera Parshall Shiffman Memorial Library will be to make its medical volumes — up to 180,000 — easily available to patrons. The design provides a majority of space on all three levels for reading and for shelving. The 68,178-square-foot medical library will be finished in 1970.



AT LEFT, Mrs. Norman J. Levey, Detroit, and Mrs. Robert I. Kohn, Shaker Heights, Ohio, daughters of Abraham Shiffman, were guests of honor at groundbreaking ceremonies for the Shiffman Library. Their father, through the Shiffman Foundation, made a major financial contribution.

National Nutrition Study Underway in Michigan



BIOCHEMICAL, DENTAL AND dietetic information is collected by health personnel like Zelma Cabe, left, a blood technician. The current survey is the first such nutritional study of Michigan in 20 years.

A TOTAL OF 2,000 Michigan families will be interviewed. Below, John Bigelow, urban research consultant, checks data secured by Margaret Blunt, left, and Betty Behnke, nutrition field surveyors.





EATING UTENSILS HELP Nutritionist Nel Williams demonstrate the values of certain foods. Early findings of the national study indicate an alarming prevalence of disease due to undernourishment and ignorance of diet as a major factor.



THE MAJOR EFFORT for the National Nutrition Study which will reach 23 Michigan counties is being concentrated in the Detroit Area, where these survey teams, at right, are briefed by Mrs. Alice Smith, field director.

THE ONLY spark-image camera reportedly in the nation is at work in the division of radiologic physics at William Beaumont Hospital in Royal Oak. The camera detects thyroid abnormalities at early stages by photographing radioactive isotopes in the patient's thyroid through a spark chamber filled with neon gas. Inventor of the instrument is Norman H. Horwitz, Ph.D., a radiologic physicist who has also been an engineer with shop experience. Doctor Horwitz, at right in photo below, demonstrates the machine with Kenneth Cook, a design engineer who assists Doctor Horwitz in his machine shop in a storage section of the hospital. Doctor Horwitz is also the inventor of a blood analyzer used to detect how a patient's thyroid is affecting properties of his blood.





NEW BRACES were the object when 10-year-old Dorothy Hohl, above, visited James Albright, M.D., an orthopedist at Yale University School of Medicine. Doctor Albright is working to find the metabolic factors which may cause osteongenesis imperfecta, the condition the young girl is afflicted with. Doctor Albright's project is funded by the National Easter Seal Society for Crippled Children and Adults, which provided direct treatment and other services to more than 253,000 crippled children and adults last year. Contributions made during the annual appeal are the major source of financing for 2,844 Easter Seal facilities and programs. The campaign to sell Easter Seals extends from March 1 to April 6 this year.

WORK IS UNDERWAY on the new Michigan Blue Shield-Blue Cross Service Center in downtown Detroit. The functional Service Center, located several blocks from the present Jefferson headquarters near Congress and the Chrysler Expressway, will include a twenty-two-story administration building, a three-story computer support facility, and a five-deck parking garage.



'THE INTERNIST AND TOTAL CANCER CARE'

Michigan Doctors who attended The American College of Physicians (ACP) January conference, "The Internist and Total Cancer Care," are still talking about the excellence of the educational seminars. Aided by the Michigan Cancer Foundation (MCF), Henry Ford Hospital and Wayne State University, the ACP presented what were called "the best classes on Cancer we've attended," by every postgraduate student questioned. Director of the five-day conference was Michael J. Brennan, M.D., F.A.C.P., MCF president. His co-directors were Robert W. Talley, M.D., F.A.C.P., chief of the Oncology Division, Henry Ford Hospital, and Vainutis K. Vaitkevicius, M.S., M.D., F.A.C.P., WSU professor of oncology. All three doctors are MSMS members.



DISCUSSING SEMINAR during coffee break are K. Charles Wright, M.D., Marquette, left, and R. W. Talley, M.D., F.A.C.P., co-director of the course and Chief of Oncology at Ford Hospital.



Michael J. Brennan, M.D., F.A.C.P., directed "The Internist and Total Cancer Care" seminar. He is president of the Michigan Cancer Foundation, professor of medicine at WSU, and a Senior Associate in Medicine at Detroit General Hospital.

ANSWERING QUESTIONS on his paper, "Practical Intra-Arterial Chemotherapy," is Melvin Reed, M.D., assistant clinical director of MCF's Darling Memorial Center in Detroit.



this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement
to facilitate healing
in chronic cutaneous ulcers...

Elase® Ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

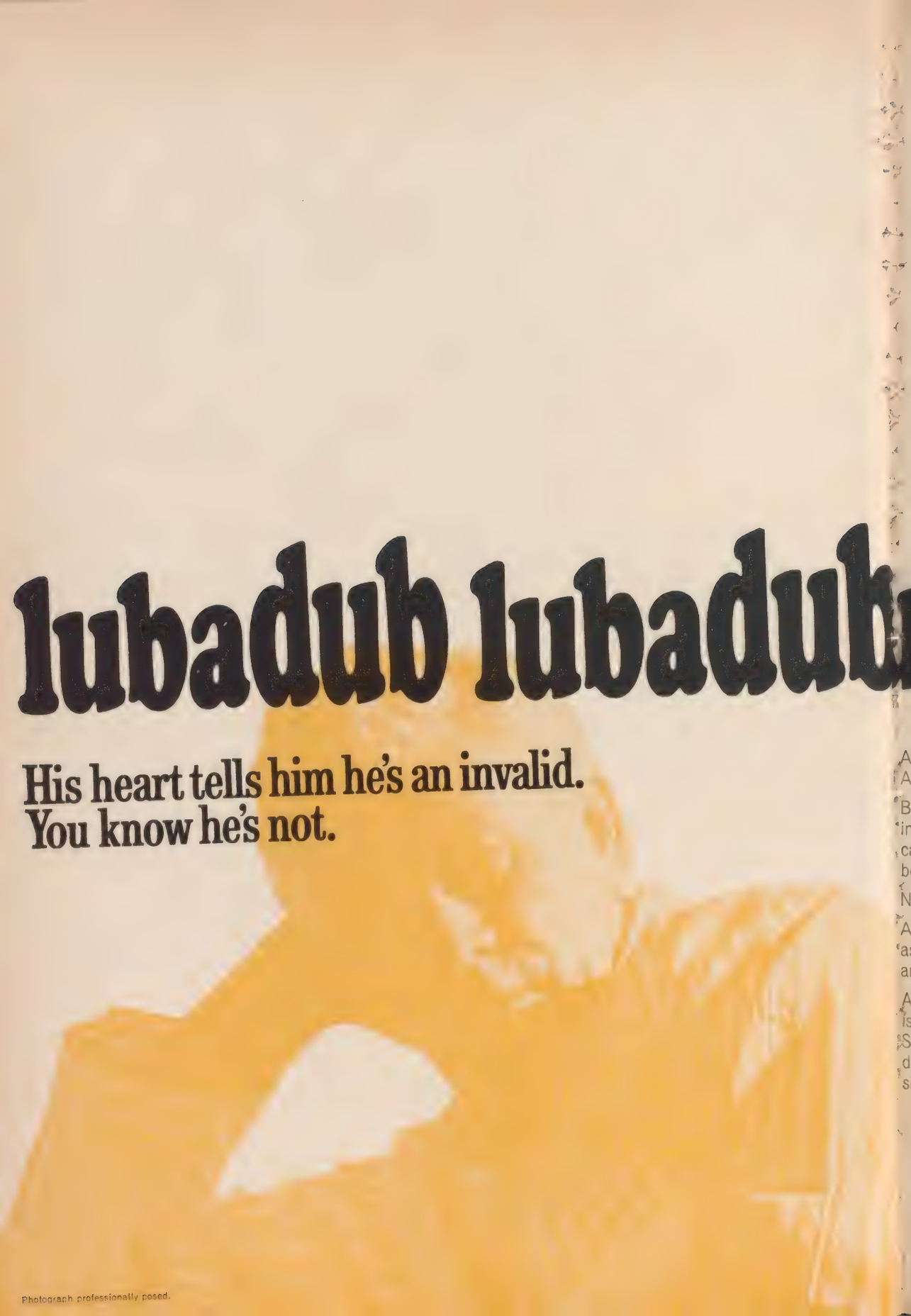
PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation . . . *for healing*. Its lytic enzymes effectively break down DNA in dead leukocytes and other debris . . . the fibrin in blood clots, serum, and purulent exudates . . . and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48160



lubadub lubadub lubadub lubadu

His heart tells him he's an invalid. You know he's not.

Photograph professionally posed.

Anxiety is expected in the cardiovascular patient. A little may even be desirable.

But when anxiety is exaggerated . . . when it interferes with sleep . . . when it aggravates cardiovascular symptoms, your help may be needed.

Naturally, you'll want to reassure the patient.

And perhaps prescribe Equanil (meprobamate) as adjunctive therapy. It helps relieve anxiety and tension specifically, yet gently.

Almost 15 years' use has shown that Equanil is usually well tolerated as well as effective. Side effects are generally limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) Wyeth®



A little sunshine for summer cold and allergy sufferers.

Novahistine LP can brighten things in a hurry for your summer cold and allergy patients.
These continuous-release, decongestant tablets contain a vasoconstrictor-antihistamine formulation that goes to work promptly and usually provides effective relief even in those cases of nasal congestion caused by repeated allergic episodes.
And, convenient twice-a-day dosage with Novahistine LP lets most patients enjoy relief all day and all night.
Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of
The Dow Chemical Company,
Indianapolis, Indiana.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW

State Auxiliary Health Careers Chairman Outlines Comprehensive Action Plan

Encouraging and assisting county chairmen with health career recruitment is a tremendous challenge, observes Mrs. Carl H. Mangelsdorf of Flint, MSMS Woman's Auxiliary Health Careers Chairman.

"But I think we women can do a lot," she says. Mrs. Mangelsdorf, who was selected for the state auxiliary responsibility in September, has outlined a comprehensive plan of action for auxiliary members across Michigan.

"The basic problem is how to get to youth," says Mrs. Mangelsdorf, pointing out that the theme of the year's efforts by the national auxiliary is "Accent On Youth."

"As an auxiliary, we are committed to do all we can to alleviate the critical health manpower shortage," wrote Mrs. Mangelsdorf in a recent letter to county chairmen. She suggested that county auxiliaries work closely with their county medical societies, local organizations, schools, hospitals and institutions. She urges the chairmen to inform their community of health careers and the shortage of medical personnel by using all the news media and disseminating printed materials to schools and key public places.

She particularly directs the health career chairmen to work with school counselors throughout Michigan. "I strongly urge that you become personally acquainted with the high school counselors in your area and offer them your assistance," she wrote in her letter. She encourages the chairmen to be resource persons for the counselors, obtaining current reference materials and information on health careers, planning school health career days, planning area-wide counselors' dinners or at-home coffees to alert counselors to the chairman's interest in health recruitment. "Information on health careers in some schools is inadequate and outdated," she says. "School counselors need your assistance."

The county auxiliaries also are encouraged to sponsor visits of the Michigan Health Association Health Careersmobile to their areas, arrange student visits to colleges and universities, raise funds for scholarships, and encourage colleges and training centers to promote additional health allied courses and refresher courses to recall retired health personnel.

Mrs. Mangelsdorf is proud of the health career activities being carried out throughout the state. "Several auxiliaries are initiating or expanding health career clubs." She points out, with particular pleasure that Genesee, her home county, has volunteer student workers from 34 schools working in four Flint-area hospitals. These students, mostly members of health career clubs, give thousands of hours of volunteer work each year to the hospitals and are awarded caps and stripes for their efforts. The woman's auxiliary acts as a liaison between the hospitals and school organizations sponsoring the student volunteers.

Calhoun County has formed its own Health Careers Council and several counties sponsor fund-raising projects to provide scholarship funds, organize Health Career Days or Fairs and are increasing their efforts to compile information for school counselors.

Mrs. Mangelsdorf works with the Michigan Health Council, as the Woman's Auxiliary representative, and informs her chairmen of information and services available from the Council, including films, brochures, posters and speakers. She is hopeful that in conjunction with the Michigan Health Council, it will be possible to provide a quick reference directory of health career information, in the future, including high school courses to take in preparation, types of health career courses offered at schools in Michigan, positions that don't require a college education, expected salary levels, scholarships available, etc. — to be provided to Michigan high school counselors for assisting students,

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan — MU 5-8441

M. Leroy Barry, M.D.

Dan W. Everett, M.D.
Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization[1] — provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste — confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[2]

Concomitant relief of G. I. gas distress — provided by the proven antiflatulent action of simethicone[3].

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonsful to be taken between meals and at bedtime, or as directed by physician.

References: 1. Merck & Co., Merck Chemical Division: Antacid Literature Survey, Rahway, New Jersey. (MM3041, R-1286-K REV 463.) 2. Danhof, I.E., report on file. 3. Hoon, J.R.: Arch. Surg. 93:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109



ANCILLARY

Inner City Students Latest to Reap "Sugar Cube" Benefits

The Detroit-area public continues to receive benefits from the surplus of donations made to the sugar-cube polio vaccine campaign of several years ago.

The Wayne County Medical Society determined when an excess of money was left over after campaign expenses were paid, that the funds should be expended for the benefit of the public. Thus a Wayne County Health Foundation was formed to take charge.

The Board of Trustees of the Foundation, which consists of a few members of the society and other interested citizens, is led by Donald N. Sweeny, Jr., M.D., also chairman of the MSMS Judicial Commission.

Among the Foundation's recent allocations have been $10,000 to the Wayne State University School of Nursing for scholarships, and $2,000 to the Riverside Civic Fund to run its medical clinic on the lower east side as a plan in community medicine.

An additional $7,500 has been allocated to WSU for scholarships for black inner city students in their first year of nurses training. The grants were made through the nursing subcommittee of the Detroit Commission on Community Relations. All those receiving aid are students who have been interested in pursuing professional nursing careers through the counseling of Mrs. Helen Garvin, special nursing counselor in the Detroit Public Schools.

MHC Schedules Annual Congress At Towsley Center

The Michigan Health Council will hold its annual Michigan Health Congress May 21 at the new Towsley Center for Continuing Education in the Health Sciences at the University of Michigan Medical Center.

Several hundred persons are expected to attend the Congress, planned as a feature of Michigan Week. The program will also pay tribute to the 100th anniversary celebration of the University Hospital. Gov. William G. Milliken has been invited to speak at the evening banquet which will conclude the congress.

The meeting will be one of the first major conferences to be held at the new center provided by funds from the Harry A. and Margaret Towsley Foundation and the Dow Foundation.

Topics will deal with health manpower, health careers, and health education. Auxiliary members with interest in health careers are invited to attend.

A special meeting is planned on the critical health problems affecting Michigan's children and youth, such as drug abuse, smoking, alcohol, and health quackery.

Those wishing further information may contact John A. Doherty, executive director, Michigan Health Council, 712 Abbott, East Lansing 48823.

Nurses Association Schedules Dean Hunt

A new series of spring conferences, sponsored by the Michigan Nurses Association and seeking to identify the role of nursing, will feature Andrew Hunt, Jr., M.D., dean of the Michigan State University College of Human Medicine.

The series, titled "Wednesdays with MNA," began March 12 and will continue each Wednesday until June 11. On the last date, Dean Hunt will discuss, "Barriers in Providing Health Care to People," at 10:30 a.m. at the Lansing Civic Center.

The spring conferences have been designed as small group workshops to meet specific clinical and occupational needs of MNA members.

SMITH, KLINE CATALOG AVAILABLE

Smith, Kline and French laboratories have just released a new *SK & F Services Catalog,* available to physicians without charge. The 50-page catalog includes listings of medical films, booklets, periodicals, Speakers Bureau, the "Code 4" cardiopulmonary resuscitation training program and a new film, "Shock, Recognition and Management." Those interested may write Smith, Kline and French laboratories, 1500 Spring Garden, Philadelphia, Pa.

Physician's Appointment Brings Medicine Social Security Closer

A recent action by the Social Security Administration should serve to further enhance communications with the medical profession. Theodore C. Bedwell, Jr., M.D., has been named to the position of Chief Medical Officer for the Medicare program.

With the appointment of Doctor Bedwell, SSA liaison with state medical associations will be expanded and hopefully will serve to expedite consideration of medical issues. The added support for professional relations and strengthened communications is expected to be maintained in close coordination with the Council on Medical Service.

The AMA Council on Medical Services is in accord fully with the expanded professional relations program.

We urge that state associations keep the AMA Council informed as it has heretofore with regard to local and area problems involved in the administration and operation of the Medicare program. The continued exchange of information may assist in identifying those that are common to different areas and make a central approach to a resolution more effective.

John M. Rumsey, M.D., Chairman
AMA Council on Medical Service
Chicago

MAY U-M CONFERENCE FOR EMERGENCY WORKERS

The Annual Conference on the Initial Management of the Acutely Ill or Injured Patient is planned for May 26-28 at the Horace H. Rackham Building of The University of Michigan. Members of the U-M Medical School faculty will speak.

Planners of the program, who represent police, fire, medical, Red Cross, industrial, and other emergency agencies, are directing the conference toward the emergency worker with emphasis on the practical aspects of emergency care. A new section on water accidents will be included.

THYROID WORKSHOP SEEKS ABSTRACTS

Michigan physicians are invited to submit abstracts for the Ninth Annual Workshop sponsored by the Wayne State University Thyroid Service. The meeting is scheduled Dec. 10 at the David Whitney Building, 1010 Antietam, Detroit.

Abstracts are to be submitted to Robert C. Douglass, M.D., 23023 Orchard Lake Road, Farmington 48024, by Aug. 1. Those wishing further information may contact Doctor Douglass.

Medical Profiles To Be Speeded By Computer System

A new computer-based system to provide a faster, more efficient method for gathering and correlating the information required for a medical profile is being developed for an Ann Arbor firm.

The new system will accumulate data from physical examinations and print detailed reports on each patient's condition for use by the physician as an aid in diagnosis and screening for early symptoms of disease.

Preventicare Systems, Inc., the Ann Arbor firm, is planning to open a multiphasic screening center in the Detroit area during the coming year. With the computer it hopes to obtain comprehensive test profiles on as many as 100 patients a day.

The approach is also expected to reduce serious illness, particularly in older people, by helping physicians to detect diseases at an early stage; raise community health standards by making it possible for large segments of the population to have regular physical exams; ease the burden on over-crowded hospitals and enable physicians to reserve bed space for their patients in advance, and provide more accurate information for medical research, census reports and actuarial records.

Medical profiles prepared by Preventicare will be based on laboratory analyses, X-rays, a computer-interpreted electrocardiogram and a series of questions asked of the patient by the screening center's staff. The computer will be programmed to sort out and print a report than pinpoints those items which indicate possible illness.

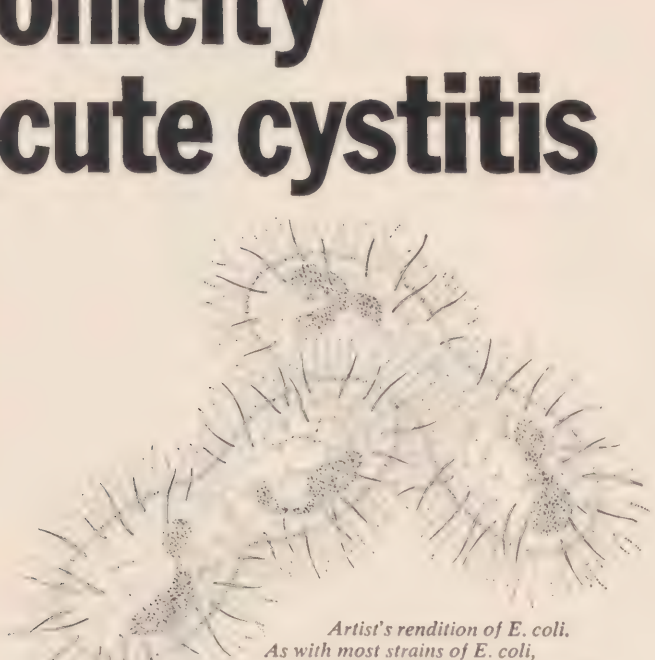
PKU TEST RESULTS ANNOUNCED BY STATE HEALTH DEPARTMENT

Preliminary statistics of the State Department of Public Health released recently indicate that 29 children have been diagnosed as afflicted with Phenylketonuria (PKU) since 1963 when PKU testing began in Michigan.

PKU, an inherited disorder in which the body cannot dispose of phenylalanine, causes permanent damage to the infant's brain cells and results in severe mental retardation if not detected. Proper treatment including a diet low in phenylalanine can prevent mental retardation.

PKU screening began on a limited basis in 1962 and three years later state law made such tests mandatory for every Michigan newborn within the first two weeks after birth. Since the beginning of the program, the department said, one confirmed case has been found for about every 20,000 infants tested. For every positively diagnosed case of PKU there have been about 15 suspected cases which after careful study were determined not to be PKU, the department said.

To help avert chronicity in acute cystitis



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

Although it may coexist with chronic pyelonephritis or prostatitis, many cases of chronic cystitis may result from incomplete treatment of a simple, acute cystitis. For this reason, it is being increasingly recommended that appropriate antibacterial therapy in full dosage be maintained for up to two weeks or longer.

Most frequently, the dominant pathogen is gram-negative, usually *E. coli;* most often, you will find Gantanol® (sulfamethoxazole) effective against *E. coli* and other sensitive organisms—gram-positive and gram-negative—commonly seen in cystitis and other urinary tract infections. Wide clinical usage of Gantanol has confirmed the efficacy of this wide-spectrum antimicrobial agent in the treatment of cystitis.

The rapidity of bacterial multiplication in a favorable urinary environment is well known. Prompt control of acute bladder infection is therefore essential

---

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended

not only to reduce the patient's discomfort but to prevent chronicity and possible ascending infection.

Gantanol (sulfamethoxazole) provides antibacterial activity within two hours of the initial 2-Gm dose, and subsequent 1-Gm doses, taken morning and evening, maintain therapeutic blood and urine levels lasting up to 12 hours. Significant symptomatic response is frequently achieved within 24 to 48 hours in acute, uncomplicated cystitis and other responsive urinary tract infections. In addition, Gantanol is usually well tolerated. Should prolonged therapy be required, the convenient *b.i.d.* dosage helps to minimize the problem of skipped doses.

Over eight years' clinical use has thoroughly demonstrated the qualities that make Gantanol a good choice for initial therapy of most urinary tract infections, including acute cystitis.

---

for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days.* Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Gantanol®
(sulfamethoxazole)
assures rapid, sustained, antibacterial activity with b.i.d. dosage

Gantanol® B.I.D.
(sulfamethoxazole)



Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Dean Hubbard To Take On Additional Duties

William N. Hubbard, Jr., M.D., Dean of the University of Michigan Medical School for the past 10 years, will take on additional duties as director of the U-M Medical Center on July 1.

University Regents appointed him to the new combined position; which recognizes that in the Medical Center teaching, patient care, and research are inseparable. The director of the Medical Center will be responsible for this intersection of hospital and academic functions. The U-M reports, that, "In his new position Dr. Hubbard will have broad responsibilities for coordinating activities of the school and hospital; for enhancing the relationship between the Medical Center on the one hand and the rest of the University and society on the other, and for achieving and utilizing financial support for the center's activities." The U-M reports that Dr. Hubbard, who will remain dean, probably will delegate strictly educational functions.

Matters strictly concerning the hospital will continue to be the responsibility of the hospital director, who will report to the director of the Medical Center. A. C. Kerlikowske, M.D., is retiring on June 30, after 24 years as hospital director. A successor will be appointed by the Regents.

Dr. Hubbard became U-M dean in 1959, from the New York University College of Medicine, where he was associate dean.

MSMAS RESCHEDULES ANNUAL SESSION

The Michigan State Medical Assistants Society, which customarily meets during the MSMS Annual Session, instead will meet next April 23-26, 1970. The MSMAS meeting is tentatively scheduled at the Pontchartrain Hotel, Detroit.

ACS ANNUAL MEETING APRIL 24 - 25 IN ANN ARBOR

Selected surgical papers by residents and panel discussions of Trauma, Surgical Infections and Management of Patients with Advanced Malignancies will highlight the 18th Annual Meeting of the Michigan Chapter, American College of Surgeons, April 24 and 25 at the Statler Hilton in Ann Arbor.

The Frederick A. Coller Award will be presented for the best presentation of the papers by surgical residents on Thursday. In addition there will be monetary awards for first, second and third prize. Preston Wade, president of the American College of Surgeons, will assist at the judging.

Chairing the panels will be Carl Moyer, M.D., Baraga, and George Moore, M.D., Director, Roswell-Park Memorial Institute, Buffalo, N.Y.

COMPLETE PROGRAM 20th ANNUAL SCIENTIFIC SESSIONS MICHIGAN HEART ASSOCIATION

Cardiac Therapy is the general theme of the 20th annual Scientific Sessions scheduled by the Michigan Heart Association on April 11 and 12 at the Sheraton Cadillac Hotel in Detroit.

Following is the complete program:

FRIDAY, APRIL 11

AFTERNOON PROGRAM — CORONARY CARE UNITS, DONALD C. OVERY, CHAIRMAN

p.m.
2:00 — Welcome, Michael C. Kozonis, M.D.

2:05 — Changing Concepts in Coronary Care. Clinical and Physiological Studies in Acute Myocardial Infarction, Thomas Killip, III, M.D.
— Treatment of Arrhythmias in Myocardial Infarction, Leonard S. Dreifus, M.D.
— Panel

SATURDAY, APRIL 12

MORNING PROGRAM — CORONARY ARTERY DISEASE, MICHAEL C. KOZONIS, M.D., CHAIRMAN

a.m.
9:00 — Foxglove to Beta Blockers, Leonard S. Dreifus, M.D.
— The Role of Exercise in the Discovery, Evaluation and Management of Coronary Insufficiency, Albert A. Kattus, M.D.
— The Frank N. Wilson - Gordon O. Myers Lecture, Coronary Heart Disease — 1969, R. Bruce Logue, M.D.

10:45 — Intermission

11:15 — Panel

AFTERNOON PROGRAM — THROMBOEMBOLISM, EDWARD W. GREEN, M.D., CHAIRMAN

p.m.
1:30 — The Clinical Recognition and Management of Pulmonary Embolism, R. Bruce Logue, M.D.
— The Role of Scanning in Pulmonary Embolism, Henry N. Wagner, Jr., M.D.
— Arteriographic Diagnosis of Pulmonary Thromboembolism, James K. Alexander, M.D.
— Panel

The AMBAR SCRAPBOOK of Obesity Oddities
FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A·H·ROBINS



NOYES L. AVERY, M.D., examines one of three children in a family. He occasionally handles matters outside his practice of internal medicine when working at the Franklin-Hall Health Clinic in Grand Rapids.

Despite Dissent, Grand Rapids To Enlarge Facility For Free Medical Care Of Indigent

BY WILLIAM J. SCHIFFEL
GRAND RAPIDS SCIENCE WRITER

The Franklin-Hall Health Clinic, Grand Rapids' experiment in providing volunteer medical personnel to bring free care to the medically indigent, is starting its second year with as much divided opinion as when it first opened its doors.

There are physicians who feel the clinic is filling an important need in the inner city. There are others who are convinced the entire idea is poor medicine. But in spite of the professional dissension, the people served by the clinic — those unable to afford private care and ineligible for government-assisted programs — have accepted the clinic almost without reservation.

The purpose of the clinic is twofold: to provide a community-centered facility for screening, diagno is and treatment, and to ensure that those patients who need additional treatment are referred either to a private physician or to one of Grand Rapids' hospital clinics.

"If we consider the primary function is to bring people into the mainstream of medical care then the clinic is serving a very useful purpose," says Winston B. Prothro, M.D., director of the Kent County Health Department and medical director of the clinic.

Since the facility opened some 10,000 patients have been seen. "We estimate the clinic has provided about $130,000 in medical care and spent only $7,200," says James M. Riekse, M.D., co-chairman of the clinic's medical advisory committee and one of the primary proponents of the program.

The concept was formed late in 1967 at the urging of the city's Community Action Program, an agency of the Office of Economic Opportunity, and the United Community Services, funding agency for CAP. Both groups felt there was an urgent need to bring some form of medical care directly to the residents of the inner city. Dr. Riekse, who also is director of the city's Planned Parenthood program located in the Franklin-Hall Complex, attended steering committee meetings and ultimately recommended the Kent County Medical Society take an active part in the planning and operation of the clinic.

"We felt the hospital clinics simply weren't set up to meet the needs of these people," Doctor

(Continued on Page 398)

Two good reasons to specify LEDERCILLIN® VK

Potassium Phenoxymethyl Penicillin

1. It's a Lederle product.

2. Low price.

Tablets:
250 mg—100's and 1000's
For Oral Solution:
125 mg/5 cc—80 cc and 150 cc
250 mg/5 cc—80 cc and 150 cc

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York
9-7-1041/461-9

NEW



Riekse said, "but rather to meet the teaching needs of the hospitals. In addition the hospitals required appointments, charged the patient for each visit, and were located outside the inner city where many people were reluctant to go even if they had transportation."

Before the clinic opened some 140 physicians, medical and osteopathic, had volunteered part-time services. The staff also included about 80 registered nurses, 20 laboratory technicians, 30 dentists, 8 pharmacists and nearly 100 other volunteers from social workers to neighborhood teenagers.

From the beginning two general clinics have been open Monday through Friday and one Saturday. In addition specialized clinics in pediatrics, ENT, nutrition, gynecology and dental care are offered one day each week. The diagnostic reports for one recent month indicate the wide spectrum of medical problems: upper respiratory ailments (219); gastric complaints (13); dermatological pathology from impetigo to common rashes (33); ENT symptoms (87); OB-GYN (25); obesity (32); emergency cases including sprains, burns, cuts, etc. (16); emotional problems (14). In any given month 900 patients are seen, 175 immunizations and 100 tuberculosis tests are administered, and about 40 patients are referred to hospitals.

The number of patients soon made it obvious that the clinic could not continue to function as it had begun without funds for medicine, a full-time clinic director and a fulltime social worker. In October, 1968 the clinic received a $7,200 emergency grant from OEO and in January the State Health Department provided $13,000 for staff salaries.

"One of our major needs now is to establish and incorporate a nonprofit organization," Doctor Riekse says, "so we can apply for funding from the U.S. Public Health Service. Most people, including the county medical society, individual medical and osteopathic physicians, the county health department and the staff of CAP, feel the clinic is serving a definite need and are convinced we must continue its operation."



SEEING A PHYSICIAN is often a new experience for the neighborhood children and even the pre-examination interview is something to watch.

There are, though, physicians in the area who are not convinced about the merits of the clinic. Although they, without exception, ask to remain anonymous, the comment of one medical doctor typifies a commonly-held attitude.

"Frankly," he said, "the whole idea is lousy medicine. When you see a patient at the clinic you never know what care he has had previously, you really don't have the time or the equipment to do a thorough diagnosis or treatment, you don't know whether you'll ever see him again, and you have no way of knowing whether he'll keep a referral appointment." This particular doctor, despite his criticisms, has donated several hours to the clinic.

Noyes L. Avery, Jr., M.D., a Grand Rapids internist, feels that the clinic, within strict limitations, is valuable. "If we look at it solely as a screening facility and a place for treatment of the acutely ill, it seems to be serving a useful purpose, especially for those who won't or can't seek medical help elsewhere," he says.

"It's important to realize that the clinic does not and can not provide every possible service," adds Daniel F. Reardon, M.D., a pediatrician. "The facilities here must be tied in with hospital facilities, but there is a need to bring whatever we can directly to the people. For example, I just got one family started on an immunization program for their children. That in itself is a valuable service."

The real value of the program is, of course, as much dependent upon the attitude of the people it serves as on the attitude of the doctors.

Robert VanLiere is a resident of the neighborhood served by the clinic and is chairman of the Neighborhood Advisory Council, a group composed of physicians, staff and area residents which formulates most of the clinic's policies.

"If there were any complaints from the people in this neighborhood I'd be the first to hear them," Mr. VanLiere says, "and so far I've heard only one — that they have to wait too long to see a doctor once they get to the clinic. Other than that the whole thing is running so beautifully I can't think of anything we'd do differently if we were starting from scratch."

One of the secondary benefits patients derive from the clinic, Mr. VanLiere says, is the establishment of a rapport with the medical profession. "Most of the people like the idea of no red tape when they want to see a doctor. They even talk on the street about the personal treatment they get."

In spite of the present dissension about the clinic, there are plans underway to expand the program. Additional centers similar to Franklin-Hall, satellite clinics and perhaps a mobile screening unit are being discussed.

With the broad Polycillin (ampicillin trihydrate) spectrum...



...you have a lot going for you in the wide range of bacterial infections.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular.
Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).
Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.
Precautions. Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.
Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.
Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis —150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.
Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.
11-1/2/69 **A.H.F.S. Category 8:12.16**

Polycillin®
(ampicillin trihydrate)

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

BRISTOL

The penicillin you use like a broad-spectrum antibiotic



NEW MEMBERS

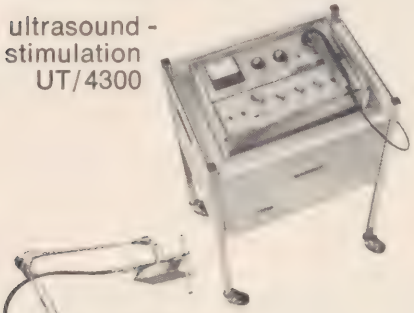
Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Donald L. Baltz, M.D., 23422 Ford Road, Dearborn Heights 48127
Marcelo Canlas, M.D., 9 Emmett Street, Leila Hospital, Battle Creek 49016
Eugene F. Claeys, M.D., 775 South Main Street, Chelsea 48118
Richard C. Dew, M.D., 2355 E. Stadium Blvd., Ann Arbor 48104
Jerome L. Epstein, M.D., 27 South Prospect, Ypsilanti 48197
Jerry M. Gray, M.D., St. Joseph Mercy Hospital, Ann Arbor 48104
Thomas J. Grifka, M.D., 1400 Chrysler Expwy., Detroit 48207
William M. Heston, III, M.D., 720 E. Catherine, Ann Arbor 48104
Lawrence E. Lee, M.D., 8425 E. 12 Mile Road, Warren 48093
Sheldon F. Markel, M.D., St. Joseph Mercy Hospital, Ann Arbor 48104
Steven A. Myers, M.D., 951 E. Lafayette, Detroit 48207
Mustafa C. Oz, M.D., Wayne County General Hospital, Eloise 48132
Maurice A. Richards, M.D., 6309 Charlevoix, Detroit 48207
Jerry C. Rosenberg, M.D., 1400 Chrysler Expwy., Detroit 48207
Jack Shartsis, M.D., Detroit General Hospital, Detroit 48226
Harold C. A. Johnson, Jr., M.D., 211 Bronson Medical Center, Kalamazoo 49006
Franklin W. Sassaman, M.D., 301 Bronson Medical Center, Kalamazoo 49006
John LeMire, M.D., 1104 S. First Ave., Escanaba 49829
Irwin P. Adelson, M.D., Detroit Psychiatric Institute, 1151 Taylor Avenue, Detroit 48202
Jerry B. Booth, DDS, 766 W. Michigan Ave., Jackson 49201
M. C. Burton, Jr., M.D., 3060 Cascade Road, S.E., Grand Rapids 49506
Robert O. Coe, M.D., University Hospital, Ann Arbor 48104
F. C. Lepperd, Jr., M.D., 1500 Weiss St., Saginaw 48602
Walter W. Shervington, M.D., 2794 Page Street, Ann Arbor 48104
Thomas S. Wittman, DDS, 761 W. Michigan Ave., Jackson 49201
Joseph M. Beals, M.D., 17894 Mack, Grosse Pointe 48224
Raymond C. Bernreuter, M.D., 213 Clark St., Saline 48176
Seong H. Chi, M.D., Ingham Medical Hospital, Lansing 48910
John DeBruin, Jr., M.D., 903 E. Grand River, East Lansing 48823
Feliciano Ferrer, M.D., 25210 Grand River, Detroit 48240.
Robert W. Gillies, M.D., 100 Michigan St., N.E., Grand Rapids 49503
John A. Habra, M.D., 919 Chester Rd., Lansing 48912
F. James Herbertson, M.D., St. Joseph Mercy Hospital, Ann Arbor 48104
George H. Hopson, M.D., 20101 James Couzens Hwy., Detroit 48235
George E. Hug, M.D., 2765 Flushing Rd., Flint 48504
Tom Johnson, M.D., Dept. of Medicine - MSU, East Lansing 48823
Sylvia M. Koscliolek, M.D., 201 Lafayette Ave., S.E., Grand Rapids 49503
Wm. A. LeMire, III, M.D., Doctor's Park, Escanaba 49837
Aquiles G. Lira, M.D., St. Lawrence Hospital, Dept. of Radiology, Lansing 48914
Ernesto O. Lis, M.D., 721 West 6th Ave., Flint 48503
Ruben J. Marchisano, M.D., 311 E. Court St., Flint 48503
Behrouz Moghtassed, M.D., 1818 Robert T. Longway Blvd., Flint 48503.
Barnabas Newton, M.D., 401 W. Greenlawn, Lansing 48910
Ki Whan Oh, M.D., 401 W. Greenlawn, Lansing 48910
Marjorie Otero, M.D., 307 Sunnyside Dr., Flushing 48433
Maria J. Paulszny, M.D., Children's Psychiatric Hosp., Ann Arbor 48104
Wm. R. Patterson, M.D., 2015 Manchester Rd., Ann Arbor 48104
Andrew K. Poznanski, M.D., University Hospital-Radiology, Ann Arbor 48104
Gary S. Sandall, M.D., 611 Church Street, Ann Arbor 48104
Samuel T. Sandell, M.D., 6 W. St. Andrews, Duluth, Minn. 55803

a modest investment equips your office for a wider range of patient services

Consider how the Burdick **MW-200 microwave diathermy unit** can help your patients — up to 7.81° F. temperature increase five cms. deep in muscle tissue. Increases blood flow, vasodilatation and venous return in normal tissue. Simple to operate, with no tuning, no applicator-to-skin contact, no toweling. Consider how the Burdick **UT/4300 ultrasound-electrical stimulation unit** can help identify myalgic trigger-point areas quickly and simply. Either ultrasound or stimulation can be used separately or in combined therapy technic. Take a good look at your present equipment. Then contact your Burdick dealer or write The Burdick Corporation, Milton, Wisconsin 53563 for full details.

ultrasound - stimulation UT/4300





microwave diathermy MW-200

BURDICK

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit, Michigan 48201
Telephone: TEmple 2-4444

BRONCHIAL DISTRESS

mùdrane®

Emphysema, Chronic Bronchitis and Asthma are relieved in fifteen minutes by the fast-disintegrating, uncoated Mudrane tablet.

Checkpoints:

DILATES THE BRONCHI
DRAINS THE MUCUS
SEDATES MILDLY
SUSTAINED ACTION
SUPERIOR TOLERANCE

Each tablet contains:

POTASSIUM IODIDE	195 mg.
AMINOPHYLLINE	130 mg.
PHENOBARBITAL, Caution: may be habit forming.	21 mg.
EPHEDRINE HCl	16 mg.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop. Iodide contraindications: tuberculosis, pregnancy.

DOSAGE: One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

mùdrane®

BRONCHIAL DISTRESS

Vietnamese Volunteer Service "Extremely Rewarding" for Doctor Rush

BY JUDITH MARR
MANAGING EDITOR

In Vietnam, there are 16 million people. They are served by less than 1,000 physicians.

For a time last fall William E. Rush, M.D., Detroit pediatrician, helped to alleviate that desperate situation.

He served as the first American doctor on the first project sponsored by the Children's Medical Relief International Inc., a new U.S. voluntary organization devoted to establishing surgical treatment and medical training centers in developing countries. It is supported by the United States Agency for International Development.

The Michigan doctor, who is also director of medical education of Saint John Hospital, Detroit, is now telling his story to fellow Michigan physicians, recommending that they volunteer also, "particularly if they are frustrated and feel they're not answering a great need.

"It was the single most gratifying treatment period of my life," testifies the doctor.

He spent September, October, November and the first week of December in Saigon as a member of the original staff of the CMRI pilot unit, a Plastic and Reconstructive Surgical Center for children.

A LITTLE VIETNAMESE GIRL, suffering after a burn from scar tissue that immobilized her arm, was photographed by Associated Press with Detroit pediatrician William Rush, M.D., who volunteered for service in a plastic surgery clinic in Saigon last fall. The picture and story of the girl, with Doctor Rush's comments on her condition, went world-wide in the press. Doctor Rush's story accompanies this photo.



The center's team also included an Israeli plastic surgeon, an English anesthesiologist and nine nurses from several countries, including Canada, the U.S., Germany, Finland and England. The center's international staff was matched in numbers by Vietnamese counterparts.

When Doctor Rush arrived in Saigon, he found that the Tet offensive of the spring, 1968, had delayed completion of the plastic surgery center's buildings. So the medical team opened an interim unit in its own apartment quarters, converting the first floor of the apartment building to hospital units.

"We were operational," says Doctor Rush. And the facility, temporary though its accommodations were, brought to war-torn Vietnam for the first time a complete plastic and reconstructive surgery center for children to begin aiding war victims and others in need of care.

The current medical crew of the center is moving into the new and permanent headquarters this spring on the grounds of Saigon's largest medical center.

Doctor Rush and other members of the center's medical team visited hospitals in Saigon and other parts of Vietnam, describing the CMRI center, and consulting with Vietnamese physicians.

A large number of cases were referred to the center by members of the Green Berets special forces, and other military personnel, as well as by Vietnamese and American doctors.

Doctor Rush reports that 50 per cent of the center's cases suffered from birth defects, particularly cleft lips and palates, the other half from acute traumas and post-traumatic deformities. Of the post-traumatic patients, half had been injured at home, half in war action.

But even those injured at home were called "indirect war casualties" by the center's doctors. "They ended up with bad defects because there was no one to take care of them during the war," says Doctor Rush.

The plan under which Doctor Rush's group of volunteers worked was different from many others, he points out, for CMRI chose to carry out its work in Saigon in its own facility rather than in existing Vietnamese hospitals.

"We think psychologically it works better that way," explains Doctor Rush. "Some of the conditions in their hospitals are so bad we would have

(Continued on Page 407)

See next page for prescribing information



You've made it one of your specifics in acute otitis media

DECLOMYCIN
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specifics in acute otitis media

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, the most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strains may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged action permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity, onycholysis and discoloration of the nails (rare). Kidney—rise in BUN apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

398-I

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

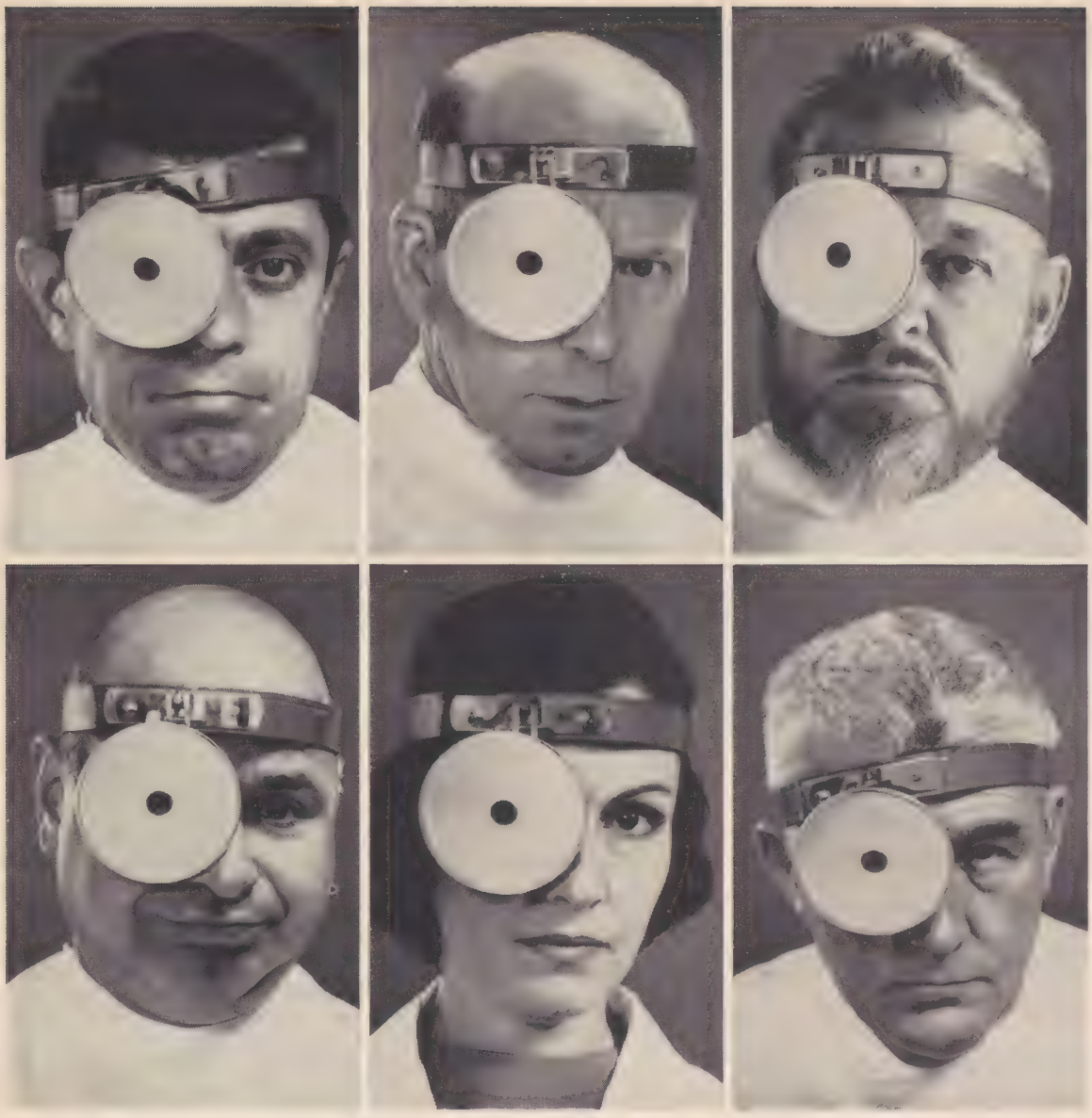
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-170



"All Otolaryngologists are Alike"

Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

Wrong! But that's no more preposterous than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more exacting. In fact, there are at least nine *specific differences* involving moisture content, purity, potency and speed of tablet disintegration, which make the manufacture of Bayer® Aspirin so different.

These Bayer standards result in significant product benefits, including gentleness to the stomach and product stability, that enable Bayer Aspirin tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that *all* aspirin tablets are alike, you can say, with confidence, that "it just isn't so."

You might also say that all otolaryngologists aren't alike, either.



PUBLIC AND PRIVATE HEALTH CARE EXPENDITURES IN THE U.S. BY TYPE OF EXPENDITURE
SELECTED FISCAL YEARS 1959-60, 1965-66 AND 1967-68 AND PERCENT INCREASES

(AMOUNTS IN MILLIONS)

Type of Expenditure	1959-60	1965-66	1967-68	Percent change 1959-60/ 1967-68	Percent change 1965-66/ 1967-68
Private expenditures	$19,971.5	$31,464.5	$33,683.0	68.7%	7.1%
Health and medical services	19,447.5	30,305.5	32,356.0	66.4	6.8
Medical-facilities construction	524.0	1,159.0	1,327.0	153.2	15.1
Public Expenditures	6,395.2	10,803.4	19,439.2	204.0	79.9
Health and medical services	5,346.3	8,683.9	16,904.8	216.2	94.7
Medical research	471.2	1,375.8	1,664.1	253.2	21.0
Medical-facilities construction	577.7	743.7	870.3	50.7	17.0
Total	$26,366.7	$42,267.9	$53,122.2	101.1	25.7

spent all our time antagonizing the Vietnamese doctors by criticizing them.

"We preferred to build from scratch, to run our facility as we thought it should be run," he continues. "By making our center a model the Vietnamese could come to work in our conditions and we could get our message across that way.

"Our methods immediately showed results. For instance we limited post-operative infection to less than five per cent, in comparison to much higher rates in other civilian hospitals in Vietnam."

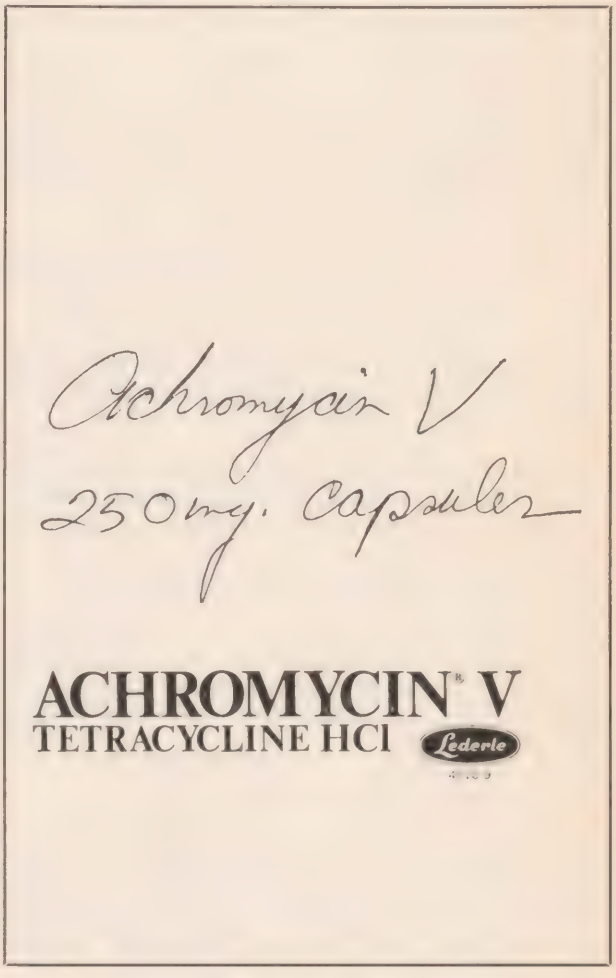
The Vietnamese cook and keep house beside the beds of family members who are hospitalized.

"But we showed them by taking good care of our patients that they didn't need to be there," recounts Doctor Rush. "For example, we cooked Vietnamese foods to their eating standards but to our nutritional standards."

Doctor Rush first learned of the CMRI project through colleagues who talked of it. Partly because of his experience with foreign medical graduates as education director at Saint John Hospital, the New York office of the corporation decided he would be a good choice to be the first American doctor to serve at the clinic.

Many doctors of every specialty, but especially general practitioners, are needed for volunteer service in Vietnam, says Doctor Rush.

And he would like to return. "I found my stay in Vietnam extremely rewarding," he says.



Wayne State Medical Alumni Celebrate 1969 Clinic Day & Alumni Reunion May 22

Sheraton-Cadillac Hotel

Downtown Detroit

Registration Opens 8 a.m.

The Wayne State University School of Medicine Alumni Association will hold its Annual Clinic Day and Alumni Reunion on Thursday, May 22, in the Sheraton-Cadillac Hotel, Detroit.

Beginning with 8 a.m. registration, events of the day will include a significant scientific program with morning and afternoon sessions, the Association's annual meeting, and a complimentary luncheon.

Highlighting the annual Reunion Dinner-Dance will be class reunions and the presentation of Golden Anniversary diplomas to the Class of 1919.

The Honorable William Milliken, Governor of the State of Michigan, will be made an Honorary Member of the Alumni Association.

Scholarship awards and other honors will also be presented, including Distinguished Service Citations to three medical alumni. They are Robert G. Axelrod, M.D., (posthumous award) who served unselfishly in Afghanistan and Israel; Lawrence A. Pratt, M.D., chief of the project, Development of Medical and Dental Education for South Vietnam, Agency for International Development; and Alice E. Palmer, M.D., (Mrs. Pratt), practicing dermatologist and adjunct associate professor, Wayne State School of Medicine, who preceded her husband as project chief in South Vietnam.

Alumni and other doctors of Medicine are cordially invited to participate in the Clinic Day Program. Reservations for the clinical program and dinner-dance may be made by writing Alumni House, Wayne State University, Detroit, Michigan 48202.



Alumni Association President James J. Aiuto, M.D., will be chairman of the morning session of the Scientific Program.



Toastmaster at the Reunion Banquet will be Jack Ryan, M.D., a 1955 graduate who is also a national collegiate debate champion. Dr. Ryan is a senior partner at the Memorial Clinic in Warren and, among other affiliations, is a member of the Board of Governors of WSU Medical Alumni.

WSU CLINIC DAY SCIENTIFIC PROGRAM ON "DRUG ABUSE"



DEMBICKI



LOWINGER



BRILLIANT



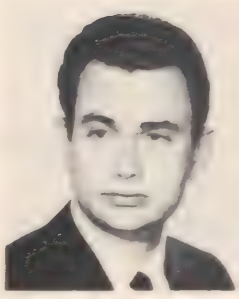
POLAKOFF



DOMINO



RASKIN



FISHER



CHAYET

EUGENE L. DEMBECKI, R.Ph.: "Patterns in Today's Abuse of Drugs." A graduate of the Wayne State University College of Pharmacy and a registered pharmacist in Michigan and Arizona, Mr. Dembicki is chief of Pharmacy Services at the Lafayette Clinic, Detroit, Michigan, and has lectured extensively on the "Abuse of Drugs."

PAUL LOWINGER, M.D.: "Pot, Perdition and Psychiatry." With an M.D. degree from the State University of Iowa in 1949, and an M.S. degree in Psychiatry from that university in 1953, Dr. Lowinger is chief of the Outpatient Service at Lafayette Clinic and associate professor of Psychiatry at the WSU School of Medicine.

LAWRENCE BRILLIANT, M.D.: "Marijuana Advice to Parents." A 1969 graduate of the WSU School of Medicine, Dr. Brilliant is associate editor of **The New Physician**, co-author with Dr. Lowinger of a forthcoming book, **Health and Human Rights**, and on the National Coordination Committee of the Student Health Organization.

PHILLIP L. POLAKOFF, M.S.: "Where is the Need? —Marijuana vs. Student." Presently a student in the WSU School of Medicine, Mr. Polakoff was president of the freshman class, and has been active in the Student Health Organization and the Student A.M.A.

EDWARD F. DOMINO, M.D.: "Clinical Pharmacology of Crude and Synthetic Marijuana Derivatives." Dr. Domino, who received his M.D. degree from the University of Illinois in 1951, is professor of Pharmacology at The University of Michigan Medical School and was consultant to the Panel on Neurological Drugs, Drug Efficacy Study, National Academy of Sciences.

HERBERT A. RASKIN, M.D.: "New Developments in the Treatment of Drug Dependence." A 1949 graduate of the WSU School of Medicine, Dr. Raskin is in the private practice of general psychiatry and psychoanalysis, while serving as adjunct associate professor of Psychiatry at the WSU School of Medicine. He is past president of the Michigan Society of Psychiatry and Neurology.

DUKE D. FISHER, M.D.: "LSD and the Hallucinogens." Dr. Fisher, who received his M.D. degree from Indiana University in 1964, is staff psychiatrist at the Naval Hospital in Oakland, California, while conducting private practice in Berkeley. He has been a consultant to many government agencies concerning "Drug Abuse."

NEIL L. CHAYET, L.L.B.: "Medicolegal Aspects of Drug Abuse." Mr. Chayet, a graduate of the Harvard Law School in 1963, is a practicing attorney with the firm of Chayet and Flash in Boston, Massachusetts. He has lectured and consulted extensively on such medico-legal matters as "Drug Abuse."

In the article BELOW is a list of 129 Michigan communities seeking family physicians. AT RIGHT is a chart of 88 Michigan communities now registered for 165 specialists. Physicians seeking to locate in Michigan communities — and communities actively looking for physicians — are served through the MD Placement Service of the Michigan Health Council, 712 Abbott, East Lansing 48823.



Wanted – By Michigan Communities – 129 Family Physicians, 165 Specialists

As a service to the people of Michigan and the profession of medicine, the Michigan Health Council conducts the M.D. Placement Program under the guidance of the Michigan State Medical Society. Inaugurated in 1953, with less than 25 Michigan communities seeking assistance, the program has expanded rapidly as the need for doctors of medicine has grown. The Michigan Health Council currently has 129 communities that are seeking general practitioners.

UPPER PENINSULA – Crystal Falls, Escanaba, Hancock-Houghton, Iron Mountain, Ishpeming, Marquette, Newberry, Rock, Sault Ste. Marie, Stephenson, Menominee, Manistique.

NORTH CENTRAL – Alpena, Atlanta, Boyne City, Charlevoix, Cheboygan, Hillman, Lincoln, Mackinac City, Onaway, Mancelona, Rogers City, Posen, Vanderbilt, Gaylord, Harbor Springs.

WEST CENTRAL – Baldwin, Barryton, Bear Lake, Big Rapids, Carson City, Cedar Springs, Crystal, Cutlerville, Edmore, Evart, Greenville, Hart, Kent City, Holton, Howard City, Lakeview, LeRoy, Manistee, Muskegon, Ovid, Portland, Ravenna, Scottville, St. Johns, Shelby, Whitehall, Zeeland, Kaleva, Reed City.

EAST CENTRAL – Byron, Caseville, Cass City, Coleman, Columbiaville-Otter Lake, Deckerville, Emmett, Flint, Gladwin, Hale, Lapeer, Lexington, Memphis, Metamora, Millington, Morrice, Mt. Pleasant, Port Huron, St. Clair, Sandusky, Pigeon, Essexville, Saginaw, Sebewaing.

SOUTHWEST – Albion, Bangor, Baroda, Battle Creek, Benton Harbor, Buchanan, Burr Oak, Charlotte, Coldwater, Eau Clair, Grand Ledge, Fennville, Hastings, Hillsdale, Jackson, Holt, Jonesville, Lansing, Lawrence, Litchfield, Marshall, Mason, Niles, Paw Paw, Plainwell, Potterville, Quincy, St. Joseph, Sturgis, Tecumseh, Waldron, Allegan, Napoleon, South Haven, Dowagiac.

SOUTHEAST – Ann Arbor, Detroit, Fowlerville, Grosse Pointe Woods, Milford, New Haven, Romeo, Saline, Sumpter Township, Troy, Whitmore Lake, Ypsilanti, Madison Heights, Royal Oak.

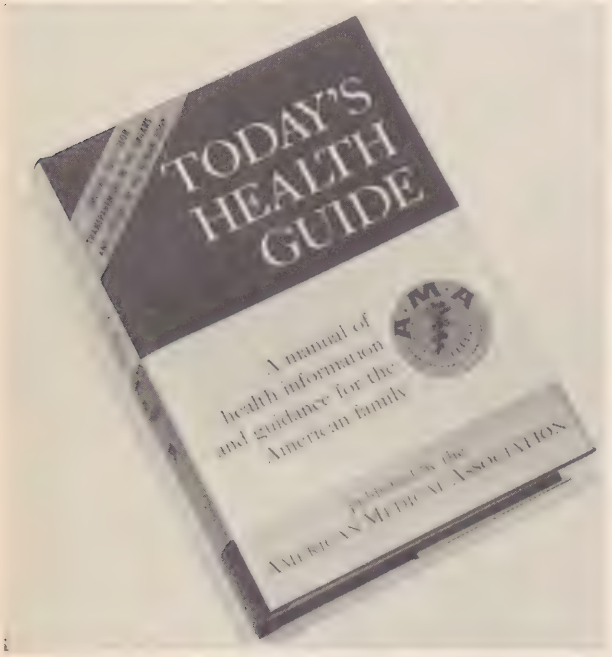
Medical specialists also are in great demand in Michigan. Seventy-five Michigan communities now are registered with the Michigan Health Council's Placement Service, some needing only one additional specialist, others seeking several physicians in the same specialty and/or a wide number of medical specialties.

The Council is working with 39 communities that are seeking internal medicine specialists, 8 that are seeking psychiatrists and/or neurologists, 15 that are seeking surgeons and 26 that are seeking pediatricians. In addition to the 165 specialty openings listed, there is a need for a rheumatologist in Grand Rapids.

For more information concerning the openings, write or phone: John A. Doherty, Executive Director, Michigan Health Council, P.O. Box 431, East Lansing, Michigan 48823; Phone: 337-1615.

	Allergy	Anesthesiology	Dermatology	ENT	EENT	Immunology	Ind. Med.	Internal Medicine	Ob-Gyn	Occupational Medicine	Ophthalmology	Orthopedics-Orthopedic Surg.	Otolaryngology	Otology	Otorhino-laryngology	Pathology	Pediatrics	Public Health	Psychiatry & Neurology	Radiology	Rheumatology	Surgery	Urology
UPPER PENINSULA																							
Crystal Falls								X															
Escanaba	X							X			X			X	X								X
Hancock-Houghton				X				X	X			X					X						X
Iron Mountain																						X	
Ishpeming-Negaunee								X				X					X						
Laurium																		X					
Marquette			X																X				
Menominee																				X			
Newberry																			X				
Sault St. Marie					X			X	X		X						X	X					
NORTH CENTRAL																							
Alpena								X				X					X						
Charlevoix								X															
Cadillac		X						X									X						
Cheboygan								X									X						
Gaylord								X															
Lake City																		X					
Rogers City								X	X								X						
Traverse City																		X					
WEST CENTRAL																							
Alma		X																					
Baldwin								X									X					X	
Grand Rapids																					X		
Grand Haven																			X				
Greenville								X	X													X	
Hart								X															
Ionia																			X				
Manistee								X			X	X					X						X
Muskegon												X						X					
St. Johns								X															
Spring Lake-Grand Haven-Ferrysburg												X											
Zeeland																						X	
EAST CENTRAL																							
Bay City																						X	
Flint																		X					
Gladwin								X														X	
Lapeer								X									X						
Midland																		X					
Mt. Pleasant				X				X	X								X		X			X	
Owosso									X								X						
Port Huron																X						X	
Saginaw								X															
St. Clair								X															
Sandusky																		X					
SOUTH WEST																							
Albion								X			X												
Allegan								X			X						X	X					
Battle Creek								X											X				
Benton Harbor															X		X						
Buchanan																	X						
Coldwater				X				X	X			X					X	X				X	X
Dowagiac																						X	
Fennville								X	X								X					X	
Galesburg									X								X					X	
Hastings								X									X						
Jackson			X					X	X		X	X	X				X			X			X
Kalamazoo							X											X				X	
Lansing								X															

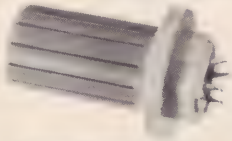
	Allergy	Anesthesiology	Dermatology	ENT	EENT	Immunology	Ind. Med.	Internal Medicine	Ob-Gyn	Occupational Medicine	Ophthalmology	Orthopedics — Orthopedic Surg.	Otolaryngology	Otology	Otorhino-laryngology	Pathology	Pediatrics	Public Health	Psychiatry & Neurology	Radiology	Rheumatology	Surgery	Urology
Marshall																	X						
Mason								X	X														
Niles					X			X				X											
Paw Paw								X														X	
St. Joseph								X					X				X		X				
South Haven									X								X					X	
SOUTH EAST																							
Ann Arbor						X		X									X						
Centerline							X																
Dearborn							X																
Detroit							X	X	X	X								X					
Eloise																		X					
Livonia								X	X														
Madison Heights				X							X		X				X						
Monroe											X												
Pontiac																		X	X				
Royal Oak								X															
Southgate								X															
Warren																	X	X					
Wayne								X															
MISCELLANEOUS																							
State-Wide Listings																							
TOTALS	1	2	2	4	2	1	4	39	14	1	8	9	3	1	2	1	26	14	8	2	1	15	5



County medical societies are purchasing copies of the AMA Today's Health Guide book for presentation to libraries, schools and other community outlets. The book, which physicians might like to have available in their waiting rooms, contains 640 pages of general advice. Copies are available at cost from the AMA at $5.95. More than 20,000 diseases, illnesses, medical conditions and subjects are thoroughly covered, with more than 300 illustrations.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 *strengths*

Android

Each yellow tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . 10 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP

HIGH POTENCY

Each red tablet contains:
Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (1/2 gr.) . . 30 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/4 gr.) . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
Glutamic Acid . . . . . 100 mg.
Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 . . . . . 2.5 mcg.
Riboflavin . . . . . 5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

also available with ESTROGEN

Android-E

Each Tablet Contains:
Methyl Testosterone . . . . . 2.5 mg.
Ethinyl Estradiol . . . . . 0.02 mg.
Thyroid Ext. (1/6 gr.) . . . . . 10 mg.
Thiamine Hydrochloride . . . . . 10 mg.
Glutamic Acid . . . . . 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen – only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

DETROIT OFFICE: G. A. Triplett, R. K. Wind and J. K. Galloway, Representatives
27200 Lahser Road, Southfield 48075 Telephone: (Area Code 313) ELgin 3-4848 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative
422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477

Committees Of The Society

ADVISORY OF PAST OFFICERS
B. M. Harris, M.D., 27 So. Prospect, Ypsilanti 48197

ADVISORY TO EXECUTIVE DIRECTOR
R. V. Taylor, M.D., 756 W. Michigan Avenue, Jackson 49201

ADVISORY TO MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY
G. E. Millard, M.D., 958 Fisher Building, Detroit 48202

ADVISORY TO WOMAN'S AUXILIARY
M. R. Weed, M.D., 1059 Berkshire Road, Grosse Pte. Park 48230

AGING
A. Hazen Price, M.D., 18605 Birchcrest Drive, Detroit 48221

ALCOHOL AND DRUG DEPENDENCE
H. A. Raskin, M.D., 18510 Meyers Road, Detroit 48235

AWARDS
C. Allen Payne, M.D., 1840 Wealthy Street, S.E., Grand Rapids 49506

BEAUMONT HOSPITAL
B. M. Harris, M.D., 27 So. Prospect, Ypsilanti 48197

BLOOD BANKS
L. W. Gardner, M.D., 60670 Outer Drive, Detroit 48235

CANCER
M. E. Dodds, M.D., 625 So. Grand Traverse, Flint 48503

CARDIAC DISEASE CONTROL
S. E. Chapin, M.D., 125 No. Military, Dearborn 48124

CHILD WELFARE
J. M. Dorsey, Jr., M.D., 31815 Southfield Road, Birmingham 48010

COMPREHENSIVE HEALTH PLANNING
R. R. Cooper, M.D., 1515 David Whitney Building, Detroit 48226

COUNTY SOCIETIES
J. J. Coury, M.D., 1209 Tenth Street, Port Huron 48060

COURSES ON MEDICAL ECONOMICS AND ETHICS
R. O. Kraft, M.D., 2355 E. Stadium Blvd., Ann Arbor 48104

DIABETES
K. K. Vining, Jr., M.D., 515 Lakeside Drive, S.E., Grand Rapids 49506

DISADVANTAGED IN CITIES
F. B. Walker, M.D., 1206 Belfour Road, Grosse Pte. 48230

EDUCATION LIAISON
M. R. Weed, M.D., 1059 Berkshire Road, Grosse Pte. Park 48230

EMERGENCY AND DISASTER MEDICAL SERVICES
C. P. Anderson, M.D., Wayne County Dept. of Social Services, 640 Temple, Detroit 48201

EYE CARE
R. T. Blackhurst, M.D., 233 E. Larkin Street, Midland 48640

FINANCE
R. K. Whiteley, M.D., 608 Eastland Center Professional Bldg., Detroit 48236

HIGHWAY INJURY
P. W. Gikas, M.D., 1900 Mershon, Ann Arbor 48103

HOSPITAL RELATIONS
A. C. Stander, M.D., 1411 Court Street, Saginaw 48602

INTERNATIONAL HEALTH
H. E. Branch, M.D., 817 Mott Foundation Building, Flint 48502

INTER-SPECIALTY
C. Allen Payne, M.D., 1840 Wealthy Street, S.E., Grand Rapids 49506

LEGAL AFFAIRS
Otto K. Engelke, M.D., 313 Washtenaw County Building, Ann Arbor 48108

LIAISON WITH MICHIGAN CHAPTER, HEALTH INSURANCE COUNCIL
B. E. Brush, M.D., 2799 W. Grand Blvd., Detroit 48202
J. J. Coury, M.D., 1209 Tenth Street, Port Huron 48060
Otto K. Engelke, M.D., 313 Washtenaw County Building, Ann Arbor 48108
R. M. Stow, M.D., 2909 E. Grand River, Lansing 48912

LIAISON WITH MICHIGAN HOSPITAL SERVICE
R. R. Cooper, M.D., 1515 David Whitney Building, Detroit 48226
J. J. Lightbody, M.D., Jennings Hospital, 7815 E. Jefferson, Detroit 48214
R. V. Taylor, M.D., 756 W. Michigan Avenue, Jackson 49201

LIAISON WITH MICHIGAN STATE PHARMACEUTICAL ASSOCIATION
H. C. Hansen, M.D., 417 Post Building, Battle Creek 49014

LIAISON WITH MICHIGAN WELFARE LEAGUE
B. M. Harris, M.D., 27 So. Prospect, Ypsilanti 48197
B. L. Masters, M.D., 111 W. Dayton Street, Fremont 49412
C. Allen Payne, M.D., 1840 Wealthy Street, S.E., Grand Rapids 49506
Otto K. Engelke, M.D., Advisor, 313 Washtenaw County Building, Ann Arbor 48108

LIAISON WITH RESIDENTS, INTERNS, SENIOR MEDICAL STUDENTS
N. D. Henderson, M.D., 726 Abbott Road, East Lansing 48823

LIAISON WITH STATE BAR OF MICHIGAN
O. J. Johnson, M.D., 207 N. Walnut, Bay City 48706

LIAISON WITH STATE BOARD OF REGISTRATION IN MEDICINE
O. J. Johnson, M.D., 207 N. Walnut, Bay City 48706

LIAISON WITH STATE EXECUTIVE OFFICE
K. H. Johnson, M.D., 1116 Michigan National Tower, Lansing 48933

MATERNAL HEALTH
J. E. Harryman, M.D., 1200 Ransom Street, Muskegon 49442

MEDICAL ASPECTS OF ORGANIZED ATHLETICS
G. A. O'Connor, M.D., University of Michigan Medical Center, Ann Arbor 48104

MEDICAL SOCIO-ECONOMICS
D. L. Kessler, M.D., 540 Belvedere Drive, S.E., Grand Rapids 49506

MEDICINE AND OSTEOPATHY
J. J. Coury, M.D., 1209 Tenth Street, Port Huron 48060

MEDICINE AND RELIGION
W. G. Fox, M.D., 715 N. University, Ann Arbor 48104

MENTAL HEALTH
Benjamin Jeffries, M.D., 19959 Vernier Road, Harper Woods 48236

NURSING
R. L. Tupper, M.D., 86 Ottawa Drive, Pontiac 48053

OCCUPATIONAL HEALTH
William Jend, Jr., M.D., 1365 Cass Avenue, Detroit 48226

PODIATRY
Wm. H. Blodgett, M.D., 1612 Kales Building, Detroit 48226

POSTGRADUATE MEDICAL EDUCATION
H. A. Towsley, M.D., W5610 University Hospital, Ann Arbor 48104

PROFESSIONAL INSURANCE PLANS
R. M. Stow, M.D., 2909 E. Grand River, Lansing 48912

PUBLIC RELATIONS
B. E. Brush, M.D., 2799 W. Grand Blvd., Detroit 48202

PUBLICATION
B. L. Masters, M.D., 111 W. Dayton Street, Fremont 49412

QUACKERY
J. N. Schaeffer, M.D., 261 Brady, Detroit 48201

REHABILITATION
L. L. Davis, M.D., 314 So. Brown Street, Mt. Pleasant 48858

RELATIVE VALUE STUDY

RESPIRATORY DISEASES
R. A. Rasmussen, M.D., 1810 Wealthy Street, S.E., Grand Rapids 49501

RURAL MEDICAL SERVICE
R. E. Rice, M.D., Memorial Clinic, Greenville 48838

SINGLE MEDICAL PRACTICE ACT
F. S. Gillett, M.D., 50 College Avenue, S.E., Grand Rapids 49503

County Society Officers

COUNTY	PRESIDENT	SECRETARY
Allegan	James I. Clark, M.D., Fennville	Van O. Keeler, M.D., 304 Dix St., Otsego 49078
Alpena-Alcona-Presque Isle	Henry B. Stibitz, M.D., Alpena	Peter Aliferis, M.D., Alpena General Hospital, Alpena 49707
Barry		
Bay-Arenac-Iosco	Walter L. Howland, M.D., Bay City	John W. Grigg, M.D., 515 Mulholland St., Bay City 48706
Berrien	Donald C. Camp, M.D., Niles	John E. Doolittle, M.D., 9 So. St. Joseph St., Niles 49120
Branch	James E. Bailey, M.D., Coldwater	Jack D. Gift, M.D., 274 E. Chicago, Coldwater 49036
Calhoun	Edward M. Chandler, M.D., Battle Creek	Melvin H. Johnson, Jr., M.D., 710 North Avenue, Battle Creek 49014
Cass		
Chippewa-Mackinac	Robert D. Heilman, M.D., Sault Ste. Marie	Earl S. Rhind, M.D., Sault Polyclinic, Sault Ste. Marie 49783
Clinton	George W. Bennett, M.D., Elsie	Bruno C. Cook, M.D., Westphalia 48894
Delta-Schoolcraft		
Dickinson-Iron	Wm. R. Gladstone, Jr., M.D., Norway	Paul L. Trump, M.D., Commercial Bank Building, Iron Mountain 49801
Eaton		
Genesee	Donald R. Bryant, M.D., Flint	James F. Dooley, M.D., 3210 S. Dort Hwy., Flint 48507
Gogebic	Paul R. Lieberthal, M.D., Ironwood	Donald L. Davidson, M.D., 200 S. Sophie St., Bessemer 49911
Grand Traverse-Leelanau-Benzie	Wm. A. Fishbeck, M.D., Traverse City	Arthur F. Dundon, M.D., 1100 Sixth St., Traverse City 49684
Gratiot-Isabella-Clare	Ray W. Chamberlain, M.D., Mt. Pleasant	James D. Klauer, M.D., Community Hospital, Mt. Pleasant 48858
Hillsdale	Edmond R. Henelt, M.D., Hillsdale	Charles T. Vear, M.D., 252 S. Howell St., Hillsdale 49242
Houghton Baraga Keweenaw	Paul S. Sloan, M.D., Houghton	Howard E. Otto, M.D., St. Joseph Hospital, Hancock 49930
Huron	Robert W. Oakes, M.D., Harbor Beach	Robert A. Willits, M.D., 193 North Main St., Elkton 48731
Ingham	Irving E. Silverman, M.D., Lansing	Robert F. Thimmig, M.D., 1322 E. Michigan Ave., Lansing 48912
Ionia-Montcalm		
Jackson	Stanley P. Olesky, M.D., Jackson	Robert E. Medlar, M.D., 719 - 17th St., Jackson 49203
Kalamazoo	Wm. D. Harrelson, M.D., Kalamazoo	John M. DeVries, M.D., 516 Whites Rd., Kalamazoo 49001
Kent	John R. Wilson, M.D., Grand Rapids	Charles A. Wilkinson, M.D., 2030 Leonard St., N.W., Grand Rapids 49504
Lapeer		
Lenawee	Marvin B. Wolf, M.D., Adrian	Richard D. Coak, M.D., 602 E. Pottawatamie St., Tecumseh 49286
Livingston	Stella Wang, M.D., Brighton	Roscoe V. Stuber, M.D., 1200 Byron Rd., Howell 48843
Luce		
Macomb	Gerald W. Morris, M.D., Mt. Clemens	Leland C. Brown, M.D., 21536 Parkway, St. Clair Shores 48082
Manistee	John F. Konopa, M.D., Manistee	Karl K. Kellawan, M.D., 52 Greenbush St., Manistee 49660
Marquette-Alger	Harry Koenig, M.D., Ishpeming	John C. Kublin, M.D., 1414 W. Fair Ave., Marquette 49855
Mason	Charles Paukstis, M.D., Ludington	James Waun, M.D., 506 E. Ludington, Ludington 49431
Mecosta-Osceola-Lake		
Menominee	Francis J. Dewane, M.D., Menominee	L. Grant Glickman, M.D., 958 First St., Menominee 49858
Midland	Charles G. Kramer, M.D., Midland	H. C. Scharnweber, M.D., P.O. Box 469, Midland 48640
Monroe	John R. King, M.D., Monroe	Rolland W. Wilkins, M.D., 118 Cole Rd., Monroe 48161
Muskegon	Frank L. Pettinga, M.D., Muskegon	Howard V. Sanden, M.D., 1643 Peck St., Muskegon 49441
Newaygo		
North Central	Clifford D. Potvin, M.D., Grayling	W. E. Bontrager, M.D., Mio 48647
Northern Michigan	Jean H. Webster, M.D., Petoskey	John E. McEnroe, M.D., Burns Clinic Medical Center, Petoskey 49770
Oakland	Ferdinand Gaensbauer, M.D., Pontiac	John H. McLaughlin, M.D., 604 North Woodward Ave., Birmingham 48011
Oceana	Willis A. Hasty, M.D., Shelby	Willis A. Hasty, M.D., 204 N. Michigan, Shelby 49455
Ontonagon	James P. Strong, M.D., Ontonagon	Karl E. Hill, M.D., 9 Hemlock St., White Pine 49971
Ottawa	Bernard M. Veenstra, M.D., Grand Haven	Jack A. Henderson, M.D., 1310 Wisconsin St., Grand Haven 49417
Saginaw	Robert I. Lurie, M.D., Saginaw	James T. Keyes, M.D., 10222 Maple Rd., Birch Run 48415
St. Clair	William J. Dinnen, Jr., M.D., Port Huron	Erwin W. Blatter, M.D., 3864 Gratiot Ave., Port Huron 48060
St. Joseph		
Sanilac	Neil Muir, M.D., Croswell	Michael H. Jayson, M.D., 2764 Lorraine St., Marlette 48453
Shiawassee		
Tuscola	Nurettin B. Gokcora, M.D., Caro	Edward J. Miles, M.D., 261 Golfview Drive, Caro 48723
Van Buren	Fredrick M. Boothby, M.D., Lawrence	Edwin H. Terwilliger, M.D., P.O. Box 110, South Haven 49090
Washtenaw		
Wayne	James C. Danforth, M.D., Gr. Pte. Wds.	George L. Reno, M.D., 970 Fisher Building, Detroit 48202
Wexford-Missaukee	Lawrence O. Garber, M.D., Cadillac	Kenneth A. Kleyn, M.D., 105½ N. Mitchell St., Cadillac 49601

Leaders of MSMS Sections

SECTION ON ALLERGY AND APPLIED IMMUNOLOGY

Chairman: Jack E. Goodwin, MD, 1600 North Michigan Avenue, #301, Saginaw 48602
Secretary: Leonard L. DiLella, MD, Henry Ford Hospital, Detroit 48202

SECTION ON ANESTHESIOLOGY & (Michigan Society of Anesthesiologists, Inc.)

Chairman: Shirley Austin, MD, 5224 St. Antoine Street, Detroit 48202
Secretary: Ralph E. Bauer, MD, Henry Ford Hospital, Detroit 48202

SECTION ON DERMATOLOGY

Chairman: Earl Rudner, MD, 7421 West Seven Mile Road, Detroit 48221
Secretary: Oscar Schwartz, MD, 16901 West 9 Mile Road, Southfield 48075

SECTION ON GASTROENTEROLOGY

Chairman: William S. Haubrich, MD, Henry Ford Hospital, Detroit
Secretary: Gustav A. Uhlich, MD, East Mitchell Road, Petoskey 49770

SECTION ON GENERAL PRACTICE

Chairman: John M. Jacobowitz, MD, Lincoln at Millard, Three Rivers 49093
Secretary: Leon Rottenberg, MD, 13419 Fenkell Avenue, Detroit 48227

SECTION ON INTERNAL MEDICINE

Chairman: John R. Caldwell, MD, 2799 West Grand Blvd., Detroit 48202
Secretary: Arthur W. Strom, MD, 32 South Broad Street, Hillsdale 49242

SECTION ON NEUROLOGY

Chairman: Edward J. Shumaker, MD, 75 Lothrop, Grosse Pointe 48236
Secretary: Marvin Margolis, MD, Detroit Psychiatric Institute, 1151 Taylor Avenue, Detroit 18202

SECTION ON OBSTETRICS-GYNECOLOGY

Chairman: Robert Walkowiak, MD, 76 West Adams Avenue, Detroit 48226
Secretary: Louis Helder, MD, 1947 Hutchinson, SE, Grand Rapids 49506

SECTION ON OCCUPATIONAL MEDICINE & (Michigan Industrial Medical Association)

Chairman: Richard W. Prior, MD, G 3248 Van Slyke, Chev. V8 Engine & Metal Fabric. Pl., Flt. 48507
Secretary: Paul E. Derleth, MD, 563 West Oakridge Avenue, Ferndale 48220

SECTION ON OPHTHALMOLOGY

Chairman: James L. Frey, MD, 1553 Woodward, Southfield 48226
Secretary: Conrad Heyner, MD, 15901 West Nine Mile Road, Southfield 48075

SECTION ON OTOLARYNGOLOGY

Chairman: Christian Helmus, MD, 203 Paris Avenue, SE, Grand Rapids 49503
Secretary: Frank Ritter, MD, 2675 Englave Drive, Ann Arbor 48103

SECTION ON ORTHOPEDIC SURGERY

Chairman: Richard W. Pomeroy, MD, Sparrow Hospital, Lansing 48912
Secretary: George Stilwill, MD, 2909 East Grand River, Lansing 48912

SECTION ON PEDIATRICS

Chairman: George L. Blum, MD, 15901 West 9 Mile Road, Southfield 48075
Secretary: William F. Howatt, MD, University Hospital, Ann Arbor 48104

SECTION ON PHYSICAL MEDICINE

Chairman: Frank Cullis, MD, 261 Mack Blvd., Detroit 48201
Secretary: Edwin M. Smith, MD, 1405 East Ann Street, Ann Arbor 48104

SECTION ON PLASTIC SURGERY

Chairman: J. H. Packer, MD, 2909 East Grand River, Lansing 48912
Secretary: Robert M. O'Neal, MD, 221 North Ingalls Street, Ann Arbor 48104

SECTION ON PROCTOLOGY

Chairman: George T. Bradley, MD, 3535 West 13 Mile Road, Royal Oak 48072
Secretary: H. J. Hazledine, MD, 4685 Lakeshore Road, Port Huron 48060

(Continued on Page 418)



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth®

SECTION ON PSYCHIATRY

Chairman: Henry Krystal, MD, Detroit Psychiatric Institute, 1151 Taylor Avenue, Detroit 48202
Secretary: Marvin Margolis, MD, Detroit Psychiatric Institute, 1151 Taylor Avenue, Detroit 48202

SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE

Chairman: Maurice S. Reizen, MD, 119 West Washtenaw Street, Lansing 48906
Secretary: Donald W. McNaughton, MD, Genesee County Health Department, Flint

SECTION ON RADIOLOGY

Chairman: Victor Curatolo, MD, 67 Cass Avenue, Mt. Clemens 48043
Secretary: David P. Corbett, MD, Harper Hospital, Detroit 48201

SECTION ON SURGERY

Chairman: Joseph Witter, MD, 134 West University Drive #304 Rochester 48063
Secretary: James W. Logie, MD, Ramona Medical Center, Grand Rapids 49506

SECTION ON THORACIC SURGERY & (Michigan Society of Thoracic Surgeons)

Chairman: Richard A. Rasmussen, MD, Blodgett Medical Building, Grand Rapids 49501
Secretary: Raymond J. Barrett, MD, 18280 Fairfield, Detroit 48221

SECTION ON UROLOGY & (Detroit Branch American Urological Society)

Chairman: Edward J. Shumaker, MD, 75 Lothrop, Detroit 48202
Secretary: James M. Pierce, Jr., MD, Wayne State University, Detroit 48207

The following sections have not submitted names of officers:

MICHIGAN ASSOCIATION OF NEUROLOGICAL SURGEONS (Section on Neurological Surgery)

SECTION ON PATHOLOGY

IN MEMORIAM

Homer A. Phillips, M.D.
Saginaw

Homer A. Phillips, M.D., Saginaw physician for over 30 years, died Feb. 8 at the age of 61.

Doctor Phillips was past president of the Saginaw chapter of the Academy of General Practice and served on the staffs of St. Luke's, St. Mary's and Saginaw General Hospitals. He was a graduate of Wayne State University College of Medicine. He was also a member of the American Public Health Association.

Clyde A. Dickinson, M.D.
Wayland

Clyde A. Dickinson, M.D., Wayland, former director of the Allegan County Health Department and a general practitioner for 33 years, died Feb. 10 at the age of 66.

Doctor Dickinson also served 33 years as county medical examiner, was a charter member of the Allegan County Medical Society and belonged to the Michigan Health Officers Association. He was graduated from the University of Illinois Medical School and was on the staff of Crispe Hospital, Plainwell; St. Mary's Hospital, Grand Rapids, and the Allegan Health Center.

David Gigliotti, M.D.
Bloomfield Township

David Gigliotti, M.D., Bloomfield Township, died Jan. 28 at the age of 56.

Doctor Gigliotti, a graduate of the Wayne State University School of Medicine, was radiologist for Providence Hospital. He also was affiliated with Dearborn Medical Center Hospital and Straith Memorial Hospital and had a private practice.

Doctor Gigliotti was certified with the American Board of Radiology and was a radiological consultant to the Michigan Bell Telephone Co.

William W. Stevenson, M.D.
Flint

William W. Stevenson, M.D., Flint eye, ear, nose and throat specialist for 47 years, died Jan. 23 in Flushing at the age of 80.

Doctor Stevenson practiced from 1919 to 1966 in Flint, was former president of the Flint Academy of Surgery and of the Genesee County Medical Society. He was a member of the American Academy of Ophthalmology and Otolaryngology and was on the general staffs of Hurley, St. Joseph and McLaren General Hospitals in Flint.

He was graduated from Rush Medical College.

"Physicians have become increasingly concerned with their need for effective continuing educational opportunities in order that the advances in medical knowledge may be applied in practice with as little delay as possible."

—AMA Guide Regarding Objectives and Basic Principles of Continuing Medical Education Programs

MICHIGAN STATE MEDICAL SOCIETY FUTURE ANNUAL SESSION DATES

1969 - Detroit, September 28-October 3
1970 - Detroit, September 20-25
1971 - Grand Rapids, October 3-8



Michigan State Medical Society
The professional association of Michigan doctors of medicine
120 West Saginaw
East Lansing, Michigan 48823

Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

PSYCHIATRIC RESIDENCIES: Approved Three-year community oriented dynamic program in Metropolitan Detroit area. University associations. Teaching staff of Board men, psychoanalysts, professors, outstanding visiting lecturers. Active research. Modern physical plant. Salary $9,875; $10,445; $11,234. Five year career program $11,234 to $20,357. Liberal Civil Service benefits. Write: Director of Education and Research, Northville State Hospital, Northville, Michigan 48167.

PSYCHIATRIC RESIDENCIES: Starting July 1969. Approved training in a mental institution with State of Michigan, Department of Mental Health. There are five year programs available. Salary $9,876-$11,233 and $11,254-$21,381. NIMH-GP stipends $12,000. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. For additional information, contact Dr. Paul Kauffman, Training Director, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

Two of the following 3 types of physicians needed immediately. $32,000 to $40,000 net first year for GENERAL SURGEON who would do some general practice; $30,000 to $35,000 net first year for INTERNIST who would do some general practice; $30,000 to $35,000 net first year for GENERAL PRACTITIONER capable of doing general surgery and salary open for GP inexperienced in general surgery. These first year incomes would be guaranteed and would depend on experience and qualifications. In addition would be included $500 worth of fringe benefits. These openings are available immediately or would sign contract if finishing residency in June. Partnership available at end of first year or sooner if agreeable. Absolutely no money needed to buy into full partnership. Would make excellent offer to two physicians who are now practicing together. Clinic net income relatively large because of high collection rate and exceedingly low overhead. Over 95% of patients are fully insured for any and all services rendered. All of the above is possible because of unique association between clinic and 3 large industries in town employing a total of 2100. Town of 3500 economically unsurpassed in many aspects located in NE Minnesota's beautiful Superior National Forest. Large unopposed clinic fully equipped in all aspects. Staff consists of 5 X-ray lab techs, 1 RN, and three secretaries. Good housing for rent or purchase. Liberal vacation and rotating night and weekend call. Fifteen minutes from modern hospital with radiology and pathology consultation. Excellent school system and most churches represented. Unexcelled hunting-fishing-snowmobiling-golfing-skiing-camping-boating-fresh air. All replies kept confidential. Call collect after 6 p.m. T. C. Leach, M.D., Babbitt, Minnesota 55706 (218) 827-6830.

G.P. Partner needed for growing practice in lower peninsula town of 2,000 population. Salary first year $20,000 and 50/50 partnership second year. Hunting, fishing, swimming, boating, skiing, canoeing, golfing nearby. Easy access to large population centers on new expressway. Reply Box 1, 120 West Saginaw Street, East Lansing, Michigan 48823.

PHYSICIANS WANTED: Internist, General Practitioner, Ob-Gyn, Orthopedist needed for additional staff to established 15-man medical group in Detroit. Excellent professional relationships. Guarantee of $25,000 minimum, plus bonuses. Reply Box #2, 120 West Saginaw Street, East Lansing, Michigan 48823.

ALPENA, MICHIGAN—Middle aged Generalist with General, Gynecological and Traumatic Surgical practice retiring due to failing health. $40M to $60M gross annually prior to restriction of activities. Excellent opportunity for a Generalist with two years Residency in General Surgery or Gynecology. Modern office building one block from center of city, complete with office equipment and clinical lab., excellent office staff; office and in-hospital surgical instruments. 200 bed modern Accredited Hospital. Complete records for 29 years. Will rent, lease, or sell building and equipment; will introduce and help in obtaining staff appointment. Will assist in financing. This is not an opportunity for a Generalist without special training as outlined above. Contact: John W. Bunting, M.D., 110 N. First St., Alpena, Michigan.

INTERNIST — Board Certified or eligible. 269-bed General Medical and Surgical Hospital in Michigan's Upper Peninsula. Licensure any state, salary dependent upon background and qualifications. Excellent benefits for retirement, vacations, sick leave, and professional improvements. Non-discrimination in employment. Contact: Chief of Staff, VA Hospital, Iron Mountain, Michigan 49801.

GP wanted for association with a surgeon and a well established general practitioner at Standish, Mich. New and progressive 80 bed hospital with CCU unit. Office space available. Financial arrangements open to discussion. Please call collect, Malcolm K. Dolbee, M.D., Area code 517-846-6122.

MEDICAL DIRECTOR: Hillsdale County, Michigan is building a new and fully equipped 160 bed Medical Care Facility which will specialize in extended care in this south central Michigan County. The city of Hillsdale is a small college community with an opportunity to establish a supplemental medical practice in conjunction with duties at the Facility. If desired, a superb opportunity will be available to supplement salary and liberal fringe benefits with geriatric-oriented research and writing. For further details contact: Robert G. Wilson, Director, Hillsdale County Dept. of Social Services, 55 Hillsdale Street, Hillsdale, Michigan 49242, or telephone (517) 437-3335.

Generalists and Psychiatrists — In accredited progressive 2000 bed mental hospital with approved psychiatric residency training program. Ideal living in active resort community located in Michigan's serene, scenic water-wonderland. Salary $20,880 to $28,480 depending on qualifications. Unparelleled retirement and fringe benefits. Contact: M. Duane Sommerness, M.D., Superintendent, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

FOR RENT: Medical suite modern air conditioned, part of Medical-Dental building in Dearborn. Excellent location. Call or write: Francis A. Lutone, D.D.S., 23401 Ford Road, Dearborn, Michigan 48128. Phone (313) LOgan 1-3367.

Index to Advertisers

They Help Make Michigan Medicine Possible

Abbott 360, 361, 362
Bristol Laboratories 399
Brown Pharmaceuticals 413
Burroughs-Wellcome 336
Classified Advertising 420
Geigy Pharmaceuticals 366, 367, 368
Glenbrook 406
Harcliffe Laboratories 328
Hoffman-LaRoche Inc. 362
Hynson, Westcott & Dunnings, Inc. .....Cover II
Ingram, G. A. Co. 363, 401
Lederle Laboratories 326, 369, 397, 403, 404, 407, 412
Lilly, Eli & Co. 340
Mallard, Inc. 337, 338
Medical Protective 413
Mercywood Hospital 421
Parke-Davis & Co. 383
Pitman-Moore Div., Dow Chemical Co. ...386, 387
Plainwell Sanitarium 388
Poythress, Wm. P. & Co. 401
Robins, A. H. & Co. 333, 395, 423, 424
Roche Laboratories .....334, 335, 392, 393, Cover IV
Sandoz 405
Searle, G. D. & Co. 372, 373
Strasenburgh Laboratories 374
Stratton, Ben P. .....Cover III
Stuart 389
Wayne State Univ. 408, 409
Winthrop Labs 371
Wyeth 384, 385, 417

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road **Conducted by Sisters of Mercy** **Ann Arbor, Michigan**

Telephone — 313 663-8571

Mercywood MERCY

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

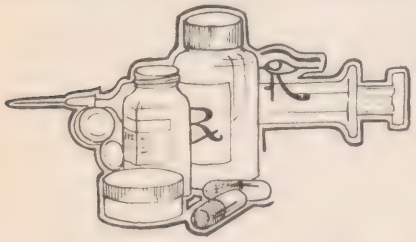
Lyle M. Allis, M.D.
Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.*
Sydney Joseph, M.D.
Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Richard D. Watkins, M.D.
Stephen C. Mason, M.D.
Philip M. Margolis, M.D.
Hubert Miller, M.D.

* 1904 - 1967

NOTES & QUOTES

BY HERB AUER, EXECUTIVE EDITOR

The practice of medicine continues to be a popular career choice among the nation's scholastic elite — semi-finalists in the National Merit Scholarship Program. Of 14,000 students honored as semi-finalists in the 13th Annual Merit program for 1967-1968, 10,779 indicated a career choice. One of every three semi-finalists indicated a decision to enter med-



icine or a closely allied field. Twenty-seven per cent of all career-decided candidates plan to become either physicians, physicists, chemists, biological scientists, biochemists, or work in other areas of scientific study and work.

* * *

The American Dental Association says in its journal that cigarette smokers are considerably more likely to suffer from gum disease and lose their teeth than nonsmokers. Researchers at Roswell Memorial Institute, Buffalo, studied 7,000 persons and concluded the periodontal condition of smokers is comparable to nonsmokers 15 years their senior.

* * *

MSMS Historian Wm. J. Stapleton, Jr., M.D., Detroit, has reason to be mighty proud of his newest "Honorary Life Membership" — one he recently received from the American Medical Society of Vienna.

* * *

Thanks to improvements in job safety an estimated 10,000 persons escaped being killed in world accidents since the end of World War II. While the work force has grown 48.8 per cent since 1945 but the number of persons killed in work accidents dropped from 16,500 to 14,200. As a result the average worker's personal chances of survival have improved 42 per cent. Information about the drop in work accidents is contained in an article in the American Mutual Insurance Alliance *Journal.*

* * *

The Bureau of Advertising reports on the results of a survey asking readers to rate why they read newspapers and magazines. The most common plus named by magazine readers was "magazines gave useful information."

* * *

"If the Post Office does become a private firm, Crotch & Dwindle will handle the account," reports S. R. Dodd, Jr., in **Marketing** and **Communications** journal. In the tongue-in-cheek article, Mr. Dodd



predicts that the make-believe Crotch & Dwindle will recommend no more mail deliveries. . . . "Anything really important can be dropped off once a month by the Avon lady, and the extra space and man-hours can go into such diversified businesses as car washes, discotheques, fried chicken franchises, etc."

* * *

The critical shortages in medical manpower — a Michigan educational effort of MSMS — will receive greater attention this coming year in Congress. Ralph W. Yarborough, Texas Democrat, who is chairman of the Senate Labor and Public Welfare Committee, has announced that he will serve also as chairman of the Health Subcommittee, and plans "to play a more decisive role in health legislation particularly in the area of manpower." Former Senator Lister B. Hill had served as the Health Committee chairman.

* * *

Before leaving office, Governor Romney sent a congratulatory message to the University of Michigan Hospital on the start of its centennial year.

"Michigan has pioneered a great number of national institutions over the years," the Governor said in a letter to hospital director, Doctor A. C. Kerlikowske, "and a hallmark of these achievements is the University Hospital at the University of Michigan."

"Established in 1869 as the first university-owned hospital in the United States, this outstanding hospital has grown steadily in stature and universal respect.

"It is indeed my pleasure as governor to salute all those individuals who have assisted in making the University Hospital the great and promising institution it is today."

The University Hospital observes its centennial this year with many special events.

* * *

James S. Imboden is the AMA's new liaison to Michigan and several other midwest states. With the AMA Public Affairs Division, he is located at 1827 Cambridge Blvd., Columbus. Mr. Imboden was formerly with AMPAC.

Leon J. Swatzell, who preceded Mr. Imboden, is now with the AMA Department of Health Manpower. He is responsible for initial AMA staff work on emerging allied health occupations.

* * *

A doctor at the Lenox Hill Hospital in NYC reports receiving the following letter:

Dear Doctor,

I have 2 children and would like to have another but I read that every 3rd baby born in the world is Chinese so I don't think I'd better take a chance, do you?

vacation in
a vial:
the spasm
reactors
in your practice
deserve



"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

A·H·ROBINS



290 tangerines or 30 Allbee® with C.

Your patient would have to peel and eat 290 tangerines a month, almost 10 every day, to get as much Vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. For example, as much niacin as 2 pounds of sirloin steak. This handy bottle of 30 Allbee with C capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.



A. H. Robins Company, Richmond, Va. 23220

DESK REFERENCE CARDS FOR STROKE REHABILITATION

INDEX ♥

PREAMBLE	1
POSITIONING AND EXERCISE: ACUTE STAGE	2
DECUBITUS ULCERS	3
BLADDER AND BOWEL TRAINING	4
COMMUNICATION DISORDERS	5
PSYCHIATRIC	6
SUPPORTIVE PSYCHOTHERAPY	6A
ACTIVITIES OF DAILY LIVING	7
UPPER EXTREMITY SUPPORT	8
PRE-AMBULATION AND TRANSFER ACTIVITIES	9
AMBULATION AND BRACING	9A
VOCATIONAL REHABILITATION	10
REFERENCES AND SUPPLIERS	11

Prepared by the Michigan Heart Association 3/69

Member: Michigan United Fund Affiliate: American Heart Association

DESK REFERENCE CARD FOR STROKE REHABILITATION No. 1

PREAMBLE ♥

The physician managing the rehabilitation program for the stroke patient should evaluate not only the physical potentials but also the social, psychological, communicative, and vocational potentials. The physician must have skill, understanding and patience to assemble available local resources and specialized services in order that the patient and his family may receive adequate treatment at the appropriate time.

The physician must be concerned with intangible factors such as patient and family attitudes, pre-morbid personality, motivation and acceptance of disability. He also must evaluate objective factors such as muscle weakness, spasticity, contractures and language deficits. These elements constitute the syndrome which requires rehabilitation services.

The following cards outline rehabilitation techniques and procedures necessary in the management of the stroke patient and show how the stroke patient can be returned to society at the highest level of function possible within the limits imposed by the damage to the central nervous system.

The Stroke Committee
Michigan Heart Association

Prepared by the Michigan Heart Association

Member: Michigan United Fund Affiliate: American Heart Association

DESK REFERENCE CARD FOR STROKE REHABILITATION No. 2

POSITIONING AND EXERCISE: ACUTE STAGE ♥

1. Maintain an adequate air-way. Keep patient's head in a neutral position as long as he is comatose.
2. **Involved arm:** if possible abduct to 45°. The forearm and elbow should rest on a pillow so that hand is higher than elbow, elbow higher than shoulder. **Support hand and wrist in position of function. See illustration.**



(OVER)

Prepared by the Michigan Heart Association

Member: Michigan United Fund Affiliate: American Heart Association

DESK REFERENCE CARD FOR STROKE REHABILITATION No. 3

DECUBITUS ULCERS ♥

A. PREVENTION:

1. Turn patient q 2h.
3. Keep patient and bed clean and dry.
4. Massage over bony prominences.
5. Inspect patient's skin frequently for signs of pressure.
6. Instruct patient concerning the relief of pressure.
7. Exercise . . . all active and passive exercises are helpful.

B. CARE AND TREATMENT:

Stage I – Reddened area without break in skin.
a. Continue general nursing care as outlined above.
b. Keep all pressure off area.

Stage II – Superficial skin break with redness.
a. Continue general nursing care as outlined above.
b. Keep all pressure off area.
c. Ultra violet light and mercurochrome painting daily.
d. Leave exposed to air as much as possible.
e. If necessary to dress area, use non-adherent dressing.

(OVER)

Prepared by the Michigan Heart Association

Member: Michigan United Fund Affiliate: American Heart Association

3. **Involved leg:** support in neutral position to prevent external rotation. Use sand bag or light blanket roll tucked under the greater trochanter. If flaccid, brace feet against footboard. In presence of spasticity use light roll under knee to avoid extensor thrust; avoid use of footboard.
4. Turn patient every 2 hours.
5. Put all limbs, especially involved side, through full passive motion at least twice daily.
6. As soon as the patient is conscious, start re-education and strengthening excercises of extremities.
7. Exercise non-affected extremities to maintain strength and mobility.

Stage III – Deep area without necrotic center.

a. Continue general nursing care as outlined above, where indicated, and keep all pressure off area.
b. Bacteriostatic soak for two hours twice daily.
c. Cover wet dressings with plastic material to prevent rapid drying of soaking agent.
d. Ultra violet and mercurochrome painting daily.
e. Leave exposed to air as much as possible.
f. Use a dry sterile non-adherent dressing when necessary.

Stage IV – Deep area with layer of necrotic tissue

a. Continue general nursing care as outlined above, and keep all pressure off area.
b. Bacteriostatic soak for two hours twice daily.
c. Cover wet dressings with plastic material to prevent rapid drying of soaking agent.
d. Following each soaking period, cover ulcer liberally with proteolytic enzyme.
e. Ultra violet light and mercurochrome painting daily.

DESK REFERENCE CARD FOR STROKE REHABILITATION No. 4

BLADDER AND BOWEL TRAINING ♥

Incontinence in the stroke patient is usually correlated with mental confusion and emotional disturbances. The patient needs reassurance that he will regain control. As he becomes more active incontinence frequently decreases and disappears. Therefore, it is important to mobilize these patients as soon as possible.

BLADDER TRAINING PROGRAM:

1. If catheter is in place for more than 24 hours—clamp for 3 h., drain and reclamp. Continue until catheter is removed.
2. Irrigate catheter BID with 10% Renacidin. Accurate measurement of intake and output is important; 3000 cc intake is necessary to maintain 1500 cc output which is considered optimal.
3. WITH IMPROVEMENT OF MENTAL STATUS REMOVE CATHETER AND OFFER URINAL OR BED PAN q 2 h. Delay in removing catheter increases chances of infection and delays resumption of voluntary bladder control.
4. As patient recovers urinary control, offer urinal or bedpan at less frequent intervals.

(OVER)

Prepared by the Michigan Heart Association
Member: Michigan United Fund Affiliate: American Heart Association

DESK REFERENCE CARD FOR STROKE REHABILITATION No. 5

COMMUNICATION DISORDERS FOLLOWING A STROKE ♥

Following a stroke, a patient may have difficulty in expressing himself or in understanding what is said, written or gestured to him. One should try to estimate the means of communication available to the patient; the objective is to find the manner in which the patient can communicate best.

The objective of treatment is to encourage the patient to use speech and other means of communication throughout his illness and recovery. Much frustration and depression can be lessened if evaluation and treatment are provided.

Terminology

Communication encompasses all forms of interaction between people.
Language refers to the symbolic use of sounds, signs, writing or gestures.
Speech is vocalized and articulated sound.
Aphasia indicates loss of language comprehension, formulation or expression when due to cerebral damage.
Receptive aphasia designates loss of comprehension.
Expressive aphasia refers to inability to formulate and produce language.
Dysphasia refers to partial loss of language function.
Dysarthria designates impairment of speech articulation due to neuromuscular damage.

(OVER)

Prepared by the Michigan Heart Association
Member: Michigan United Fund Affiliate: American Heart Association

BOWEL TRAINING PROGRAM:

Comatose Patient:

1. If coma persists more than 2-3 days, a program of bowel evacuation, using enemas, q 3 days when necessary.
2. Rectal examination should be carried out q 3 days to detect impending fecal impaction.

Conscious Patient:

1. Give cathartic or enema to remove fecal impaction. Avoid routine use unless all other methods fail.
2. SET DEFINITE TIME FOR EVACUATION, preferably after a meal.
3. Use glycerine or medicated suppositories on a planned schedule to assist developing a regular bowel habit.
4. Diet is important. Use foods that provide bulk and have laxative effect, eg prunes, prune juice, whole grain cereals, salads, etc.
5. Fluid: 2500 - 3000 cc daily.
6. Use stool softeners and bulk laxatives.
7. Keep accurate record of amount, time, character of fecal material.
8. After 1 week of satisfactory pattern, omit suppository.

COURSE OF COMMUNICATION DISORDERS

Impairment of communication after a stroke follows an unpredictable course. There may be no impairment or varying patterns and degrees of disturbance:

Complete or partial language arrest, followed by progressive improvement.
Communication impairment, followed by further deterioration.

Impairment of speech, with relative preservation of reading and speech comprehension.

Disproportionate disturbance of various modalities of communication: speaking, verbal understanding, writing, reading, calculating, gesturing.

EVALUATION OF COMMUNICATION DISORDERS

Aphasia due to acute cerebral damage should be differentiated from:

Psychological depression.
Articulatory disorders from other causes.
Mental deficiency or severe mental deterioration.
Hearing loss.
Foreign language.

See No. 5-A

DESK REFERENCE CARD FOR STROKE REHABILITATION No. 5-A

Much can be learned about the aphasic patient from his responses to ordinary conversation, from observing his behavior when he is given things to read or when he is asked to do specific things. Additional information can be gained by using the situations and objects of his environment to test his abilities. The suggested order of procedure in the evaluation is to move from the performance of complex to relatively simple tasks; if he succeeds at the complex task, there is little need to go on to the simpler tasks.

The following techniques may be useful for the physician and other professional persons working with the patient.

Expression (speaking)

Converse with the patient.

Ask him to indicate his needs or to name objects, colors, actions which he or you have performed.

Say words or phrases which you ask him to repeat after you.

Sing, and ask him to sing with you.

Stimulate his use of "automatic speech" (serial counting, naming days of the week, etc.)

(OVER)

DESK REFERENCE CARD FOR STROKE REHABILITATION No. 5-B

MANAGEMENT OF COMMUNICATION DISORDERS

These guidelines should be followed **by all people** who come in contact with the patient, **including the family and friends.**

Talk to the patient as if he understands you, whether he appears to understand or not.

See that he hears speech frequently, whether from conversation, radio or television.

Speak slowly and simply enough for his easy comprehension.

As you hand things to him, or do things for him, talk about what you are doing and what you are handing him.

Interest him in visually oriented activities – drawing, copying or tracing of letters or geometric drawings.

Try to avoid continued situations in which the patient meets frustration. Work for short periods of time.

If he cannot read, read mail, newspapers, magazines or short stories to him.

Many patients who suffer language impairment can continue to improve for months, or even years. This may be aided by training in a speech clinic or rehabilitation center.

Available for the family from the M.H.A., a free copy of "Aphasia and the Family."

Reception (response to speech)

Get him to perform acts which you command (raise your head, lift your arm, pick up your glass, open your mouth, etc.).

Ask him to identify objects (where are your glasses? show me your hand, point to my watch, etc.).

Expression (writing)

Ask him to write his name, write a short note, or write the names of some things he may want at his bedside.

Have him write in response to your dictation, a short sentence, a phrase, or the names of objects.

Have him copy a sentence, words, letters, or a simple picture, (a square, cube or star).

Reception (reading)

Give him something to read and observe whether he seems to comprehend it.

Ask him to read aloud a newspaper headline, a sentence, words, letters or numbers. Present a written command (lift your hand, nod your head, etc.).

Ask him to watch words, letters, and pictures of objects.

Use and comprehension of gesture

Ask him, or demonstrate to him, that you want him to imitate your gestures, (holding up two fingers, five fingers, lifting a glass, nodding head, rubbing chin, etc.).

See No. 5-B

DESK REFERENCE CARD FOR STROKE REHABILITATION No. 6

PSYCHIATRIC ♥

All treatment commences with an assessment of the patient's emotional state. **An attitude of understanding, receptiveness and neutrality is essential.**

The patient's emotional reactions vary with the severity of injury, premorbid personality and handling during acute stage. Psychologically, the patient has knowledge of having a stroke and experiences **physical disability** and **mental disability** due to brain trauma.

CLINICAL REACTIONS

1. Phase of Fear

Anger or depression are frequently used as defenses against the universal fear of dying. Anger directed against oneself results in depression.

Depression may be obvious or may be disguised as **inattention, confusion, anorexia,** and/or **constipation.**

2. Phase of Insecurity

May replace the phase of fear.

A patient knows he is not as capable as he was previously. He defends against this by anger or loss of self esteem or more mildly by resentment or discontent. *(OVER)*

Prepared by the Michigan Heart Association

Member: Michigan United Fund Affiliate: American Heart Association

DESK REFERENCE CARD FOR STROKE REHABILITATION No. 6-A

MANAGEMENT

1. RULES OF CONDUCT

a. Seek simplicity in all actions.
b. Keep directions simple.
c. Avoid adding to patient's difficulties.
d. Have no preconceived ideas of how patient feels.

2. SUPPORTIVE PSYCHOTHERAPY

a. Depressed patients require reassurance and encouragement.
b. Some need sympathetic approach, others firmness.
c. Some need tolerance, others stimulation.
d. All require interest and understanding, and the physician often must feel his way.
e. Resist patient's tendency to overdependence, because it interfers with rehabilitation.

While often unpleasant to work with, over-independence may indicate a greater rehabilitation potential and may facilitate the process.

f. A depressed patient requires more attention but his prognosis is better, than that of one who calmly accepts disability.

(OVER)

DISABILITIES

Physical handicaps produce differing degrees of emotional reaction. The patient who **feels** most damaged suffers the greatest emotional trauma.

Mental disabilities produce varied and emotional reactions similar to those produced by physical disability.

1. Mental changes may be expressed in loss of control of emotions characterized by "emotional lability", such as weeping, laughing, or anger produced by very slight, or inappropriate stimuli.
2. Concentration impaired; unable to maintain effort or attention.
3. Insomnia.
4. Memory impairment is characterized by the loss of memory of recent events. This may inhibit ability to relearn necessary motor skills.
5. Aphasia or Dysphasia—inability or difficulty in using and understanding language—does not indicate insanity, confusion, or total disruption of the mind. See card No. 5

Patient's understanding must be presumed to be intact until proven otherwise, but comprehension should be carefully evaluated from day to day.

See No. 6-A

REACTIONS OF THOSE CARING FOR PATIENT

The patient's illness affects others, particularly the family. The reaction of individual relatives and attendants in terms of helpfulness, cooperation, maturity, anxiety, guilt, hostility, obstructionism and ambivalence is important.

COMMUNICATION

Must be in concrete terms since the patient possibly has lost the power to be abstract and this can lead to unnecessary misunderstanding.

DRUGS

Elderly people tolerate drugs poorly. Improper dosage can cause mental confusion and paradoxical effects.

Overtreatment may be worse than the disease.

DESK REFERENCE CARD FOR STROKE REHABILITATION No. 7

ACTIVITIES OF DAILY LIVING ♥

Encourage self-care; teach patient progressively to:

(a) turn from side to side

(b) lift hips off bed

(c) come to sitting position and maintain balance with back unsupported.

1. Patient uses strong hand to place weak arm across abdomen. Slides strong foot under weak ankle; moves both legs to side of bed on strong side and over the side.
2. Turns on side, grasps edge of mattress and pushes with elbow and forearm against bed.
3. Comes to sitting position supporting body weight with strong forearm.
4. Moves hand to rear and pushes to full sitting position.
5. Moves around until sitting securely on side of bed with feet placed firmly on floor beneath the body.

(d) practice bending while in sitting position to develop stability.

(e) perform activities in self-care; eating, brushing teeth, shaving, dressing and undressing. Use involved hand as much as possible, but recognize that all these activities may be accomplished even though one side is paralyzed.

See Reference, "Up and Around," Card No. 11.

Prepared by the Michigan Heart Association

Member: Michigan United Fund Affiliate: American Heart Association

DESK REFERENCE CARD FOR STROKE REHABILITATION No. 8

UPPER EXTREMITY SUPPORT ♥

A. Hemiplegic Sling

The sling described below supports and protects the upper extremity, prevents subluxation of the shoulder joint and eliminates undue pressure on the cervical area.

Materials and Equipment:

Webbing – 1½" wide

7 Large Safety Pins

Velcro or Buckle for Chest Strap

2 Canvas or Duck Cloth Pads

Scissors

Canvas or Duck Pads: Using doubled material, cut 2 oval pieces about 5" x 10". Finish edges by binding or sewing and turning in edges.

Patient Position: Sitting as erect as possible, holding weak arm (with strong hand) at 90° angle at the elbow.

(OVER)

Prepared by the Michigan Heart Association

Member: Michigan United Fund Affiliate: American Heart Association

Starting Point: Between shoulder blade and spine on involved side.

1. Webbing is carried over involved shoulder, following parallel to arm, wrapped under forearm (about 2" - 3" from elbow joint) and up and across back. Pin at intersection of starting point.
2. Continue diagonally across back and over opposite shoulder, down to forearm at wrist joint.
3. Wrap under wrist and proceed up chest wall, around back to join webbing (over unaffected shoulder blade). Pin and cut webbing.
4. Attach horizontal arm piece at posterior band of involved arm, 3" - 4" above elbow. Proceed around arm to front band. Pin. Continue across chest to second front band, allowing length to insert into buckle if Velcro not used.
5. Position canvas pads to broaden area of support at wrist and forearm. Pin.
6. Make any adjustments prior to sewing intersections.

B. Hand Splint

Hand splint made of a light plastic material fabricated or purchased may be used to support the fingers or wrist in a functional or resting position.

This is especially effective at night to support the hand in a functional position and may be used during the day if contractures tend to develop.

See No. 8-A

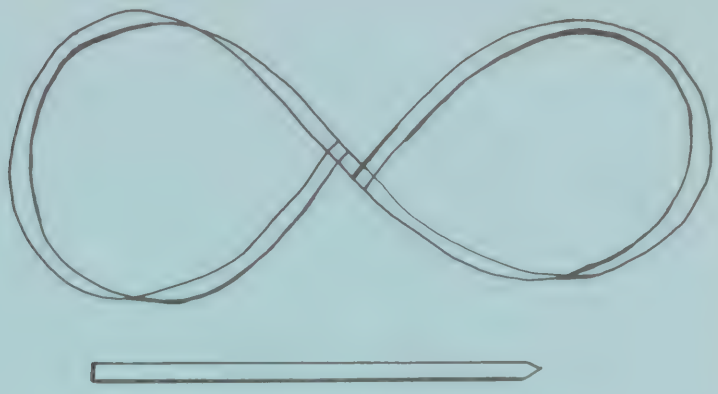


Figure 1: Sling is continuous piece of webbing, forming a figure-of-eight. Second piece forms arm band and chest strap.

(OVER)

PRE-AMBULATION ACTIVITY ♥

A. Attendant should stand on patient's strong side to encourage lateral movement toward the strong side and prevent listing toward the weak side.

B. At this time observations and recommendations should be made regarding proper prescription for support, braces and/or mechanical aids to function: braces, wheel chairs, walkers, canes, etc.

C. The patient may have good muscular strength in all extremities but may have:

1. Very poor coordination, in which case the patient should be started on coordination exercises and encouraged in wide base gait patterns.
2. The patient may have double vision — in which case a patch used alternately first on one eye for a few hours then the other will help him focus on objects.

(OVER)

Prepared by the Michigan Heart Association

Member: Michigan United Fund Affiliate: American Heart Association

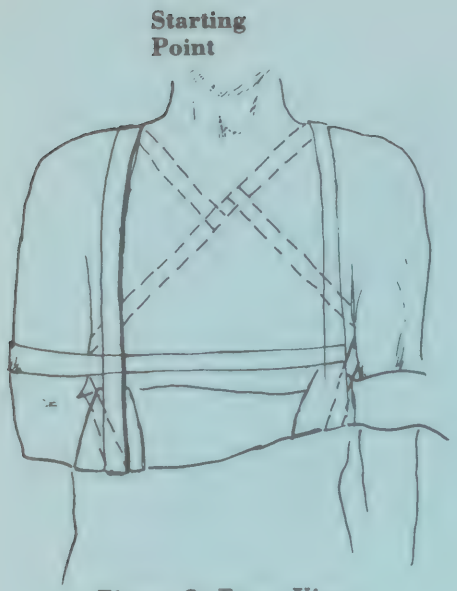


Figure 2: Front View



Figure: 3: Back View

TRANSFER ACTIVITIES

All transfer activities are done with non-involved side leading. This gives patient better control of his body. Begin under supervision of attendant, later may be performed independently.

A. From Bed to Wheelchair: Place wheelchair on patient's strong side, facing foot of bed. Lock wheelchair. Footrests up.

1. Patient comes to a sitting position on the edge of his bed as indicated on Card No. 7.
2. Patient leans forward, places the strong hand near edge of bed.
3. Pushes to a standing position, keeping weight of body over strong foot.
4. With strong hand, reaches for farther armrest of wheelchair.
5. Pivots on strong leg and lowers body to sitting position.

B. From Wheelchair to Bed: The same procedure as above is used. Remember – strong side next to bed. Patient leads with strong side.

C. Getting Out of Chairs: Place feet together squarely on the floor and under the body, bend forward; then raise up.

See No. 9-A

AMBULATION

A. Ambulation should be encouraged as soon as medically possible, using appropriate supports. See Reference Nos. 1 & 2, Card No. 11.

B. Temporary splinting with elastic bandage or posterior molds may suffice during this period of early training and evaluation. Bracing as indicated by the residual paralysis is discussed on the back of this card.

C. If the patient tends to scrape the sole of the weak foot when walking, the addition of a ¼ inch lift on the sole and heel of the strong foot will often help to correct this situation.

D. Stairs and Curbs:

1. **When going up stairs** the patient should lead with the strong leg, then bring up the weak leg to the same step.
2. **When going down stairs** the patient should go down first with the weak leg, then bring good leg to same step.
3. **Up curbs** – Lead with the strong leg, then bring up the weak leg and cane.
4. **Down Curbs** – First place cane on street, toe on strong side should extend over edge of curb. Lead with weak leg, bending strong knee as foot goes down.

(OVER)

VOCATIONAL REHABILITATION ♥

Statistics on stroke patients show that of the patients who survive the acute episode many can return to active work and others can be employed in non-competitive work either in Sheltered Workshop, Community Work or Homemaking.

When a problem in vocational relocation is apparent the patient should be referred to the local office of the Michigan Division of Vocational Rehabilitation. This agency will provide vocational evaluations followed by counseling and placement as well as providing, in selected cases, training in home-making, speech retraining, and equipment. ♥

How to Refer:

1. Submit a simple, narrative referral letter to your area DVR office (back of card) or when preferred through the regional office of the Michigan Heart Association in Traverse City, Grand Rapids, Flint, Lansing or Detroit. The DVR field representative will request any further information needed to determine eligibility for services.

(OVER)

Prepared by the Michigan Heart Association

Member: Michigan United Fund Affiliate: American Heart Association

SOME SUPPLIERS OF REHABILITATION EQUIPMENT

Many of the necessary devices can be fabricated from materials available at local hardware and department stores including shoulder pulleys, dorsiflex assists, etc. Be sure the patient receives necessary specifications.

"Fashion-Able"
Helen Gallagher Foster House
6523 North Galena Road
Peoria, Illinois 61601

Miles Kimball Co.
41 West Eight Ave.
Oshkosh, Wisconsin

Rehab Aids
7473 S. W. 8th Street
Miami, Florida 33144

Breck's of Boston
100 Breck Bldg.
Boston, Mass. 02210

B/K Lines
Box 32
Brookfield, Illinois

Vocational Guidance and
Rehabilitation Services
2239 East 55th St.
Cleveland, Ohio 44103

J. A. Preston Corporation
71 Fifth Ave.
New York, N.Y. 10003

Postage Will be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY MAIL
First Class Permit No. 14993, Detroit, Michigan

MICHIGAN HEART ASSOCIATION

13100 PURITAN AVE.

DETROIT, MICHIGAN 48227

YOU ARE ENTITLED

TO COMPLETE SERVICE CONCERNING ANY OF THE

INSURANCE PLANS SPONSORED AND ENDORSED

BY THE

MICHIGAN STATE MEDICAL SOCIETY

Group Term Life

Group Long Term Disability

Professional Overhead Expense

Accidental Death And Dismemberment

Accident & Sickness Plan For Your Employees

The Ben P. Stratton Agency, Inc. also provides complete insurance service for Professional Corporations, Partnerships, or Individuals. Your inquiries concerning valuable fringe benefits are invited. Professional Liability insurance is also available.

Call collect, or write —

BEN P. STRATTON AGENCY, INC.

MSMS Insurance Administrators

P. O. Box 547, Lansing, Michigan 48903

Telephone: (517) 484-2578

Return Postage Guaranteed

MICHIGAN STATE MEDICAL SOCIETY
120 W. Saginaw
East Lansing, Michigan 48823

M J
NLM-MX2
BOX Q
BETHESDA MARYLAND
20014



Symbols in a life of psychic tension

B.A.
cum laude

V.P.
at thirty-two

ECG
and complete examination normal

(persistent palpitations)

Valium®
(diazepam)

for reliable relief of psychic tension and associated somatic and depressive symptoms (including tension-induced insomnia)... usually well tolerated... 2-mg, 5-mg or 10-mg tablets *t.i.d.* and *h.s.*

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

NATIONAL LIBRARY OF MEDICINE
RECD. MAY 6 1969

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

APRIL, 1969 • VOLUME 68 • NUMBER 8

SEE CENTER PAGES FOR MSMS CONFERENCE PROGRAMS

MSMS Members Urged to Learn About, Support Current Society Sponsored Bills

BY M. A. RILEY
MSMS LEGISLATIVE COUNSEL

By press-time for this publication, all of MSMS'-sponsored 1969 bills have been introduced and assigned to various committees of the Michigan House and Senate with the exception of the "Single Medical Practice Act," which will be assigned bill numbers on April 15.

Legislative committees now have approximately three weeks for consideration of the nearly 3,300 proposals introduced this year. Those measures in which there is the greatest demonstrated interest—and a minimum of controversy—can be expected to be moved toward enactment into law.

Each interested member of MSMS should now review the content of the following Medical Society bills and enhance their chances for favorable action by making a point of either discussing them personally with their legislators or writing a letter to the appropriate committee in support of the bills. Address all legislators simply "State Capitol, Lansing."

Three Relate to Malpractice

Senate Bill *400* would make it clear, in alleged malpractice actions, that the statute of limitations starts running from the date of the act unless there has been fraud or intentional concealment; Senate Bill *401* would provide for a separate trial before any malpractice trial itself dealing solely with whether the statute of limitations had run out or still applied; and Senate Bill *402* would require a claimant to file a $500 bond, awarded to the physician if he was adjudged blameless, as a deterrent to nuisance suits.

All three bills are under consideration in the Senate Judiciary Committee composed of Sen. Robert Richardson, Chairman, and Senators Harvey Lodge, James Fleming, Basil Brown and Roger Craig.

Society Committee Protection Asked

Senate Bill 109 amends a 1967 state law which protected the confidentiality of records and reports released to in-hospital staff committees for purposes of functioning to reduce morbidity and mortality. The bill would extend a similar protection to similarly involved committees of MSMS, the county medical societies and the specialty societies, and was requested by the 1968 House of Delegates.

This bill is being studied by the Senate Health, Social Services and Retirement Committee led by Sen. Lorraine Beebe, Chairman, and including Senators Harry DeMaso, Alvin DeGrow, Arthur Cartwright and William Faust.

Exemption From Jury Duty

In a revision last year of the list of those exempted from jury duty, physicians were somehow excluded. House Bill 2825 would correct this situation.

The bill is before the House Judiciary Committee: Rep. Bob Traxler, Chairman, and Representatives Dan Cooper, Harold Clark, Thomas Guastello, Ted Mrozowski, James O'Neill, Edward Suski, Richard Young, Donald Holbrook, Edgar Geerlings, Joseph Swallow, William Weber, Hal Zeigler, Dennis Cawthorne and David Serotkin.

Minor Consent for VD Treatment

The bill requested by the 1968 House of Delegates to allow minors to give their own consent for VD treatment (but still allow the physician discretion to notify parents, guardians, etc., if he deems it advisable) has already passed the House of Representatives, where it was introduced. It will probably not be considered in the Senate until that body has completed work on its own bills.

The VD bill is House Bill 2080, and is now before the Senate Health, Social Services and Retire-

Learn About, Support Society's Bills

CONTINUED FROM PAGE 423

ment Committee (membership listed above).

Basic Science Repeal

House Bill 3098 would repeal the 1937 Basic Science Act. It has been introduced by the Administration, with MSMS' whole-hearted support. A similar bill has passed the House in a previous year without a dissenting vote. This now-obsolete law creates a major stumbling block in the recruitment of physicians, yet it has become obvious that maximum effort must be made to obtain its passage.

All who are aware of the difficulties of obtaining medical manpower sufficient to meet the needs of Michigan's communities should write to the House Public Health Committee composed of Rep. William Fitzgerald, Chairman, and Representatives Stanley Davis, Dan Cooper, Lucille McCollough, Joyce Symons, Dale Warner, Richard Allen, Bert Brennan and Edson Root.

Licensing and Regulation Of Hypnosis

The Council, at the request of the MSMS Mental Health Committee, has authorized introduction of a new Michigan law to regulate the teaching, inducing and practice of hypnosis. This technique would be limited to only those highly qualified by professional training and could not be used by the unqualified or for entertainment purposes.

The bill is under consideration in the House Education Committee: Rep. Lucille McCollough, Chairman, and Representatives Ted Mrozowski, Daisy Elliott, Robert Mahoney, Matthew McNeeley, George Montgomery, James Tierney, Jackie Vaughn, Clifford Smart, Thomas Brown, William Jowett, Roy Spencer and William Weber.

Health Department Employee Liability

Senate Bill 560, authorized by The Council, makes a technical but important amendment to Michigan law which will insure health department employees immunity from personal liability for damages to others unless damages were caused by gross negligence.

This bill is being studied by the Senate Committee on Health, Social Services and Retirement (listed above).

Two More Bills to be Introduced

Rounding out the 1969 MSMS Legislative Program, additional bills will be introduced prior to April 15 to create a single board of licensure for both Doctors of Medicine and Doctors of Osteopathy (companion bills will be placed in both House and Senate), and to make it possible for a malpractice insurer to make accommodation payments to an injured party without admission of liability by such action. A bill to this effect was passed in 1968 in California.

Both of these MSMS proposals will be the subject of an additional article as soon as they have been officially assigned bill numbers and referred to a committee of the Legislature for consideration.

Annual Wayne Alumni Clinic Day Planned May 22 in Detroit

The Wayne State University School of Medicine Alumni Association will hold its Annual Clinic Day and Alumni Reunion on Thursday, May 22, in the Sheraton-Cadillac Hotel, Detroit.

Beginning with 8 a.m. registration, events of the day will include a significant scientific program on Drug Abuse with morning and afternoon sessions, the Association's annual meeting, and a complimentary luncheon.

Highlighting the annual Reunion Dinner-Dance will be class reunions and the presentation of Golden Anniversary diplomas to the Class of 1919.

The Honorable William Milliken, Governor of the State of Michigan, will be made an Honorary Member of the Alumni Association.

Scholarship awards and other honors will also be presented, including Distinguished Service Citations to three medical alumni. They are Robert G. Axelrod, M.D., (posthumous award) who served unselfishly in Afghanistan and Israel; Lawrence A. Pratt, M.D., chief of the project, Development of Medical and Dental Education for South Vietnam, Agency for International Development; and Alice E. Palmer, M.D., (Mrs. Pratt), practicing dermatologist, and adjunct associate professor, Wayne State School of Medicine, who preceded her husband as project chief in South Viet Nam.

Alumni and other doctors of medicine are cordially invited to participate in the Clinic Day Program. Reservations for the clinical program and dinner-dance may be made by writing Alumni House, Wayne State University, Detroit, Michigan, 48202.

DOCTOR LIGHTBODY INVITED BY WISCONSIN SOCIETY

MSMS President James J. Lightbody, M.D., Detroit, has accepted an invitation to attend the annual meeting of the State Medical Society of Wisconsin, to be held in Milwaukee on May 13 and 14. Doctor Lightbody will be present at the Wisconsin Society's House of Delegates meeting May 14 and he and Mrs. Lightbody will attend the annual dinner that evening.

AFTER MSMS OPPOSITION

Michigan Blue Shield Postpones Action On Individual Case Participation

The Michigan Blue Shield Board of Directors has postponed until December consideration of a Blue Shield executive committee's recommendation to revoke individual case participation under the Michigan Variable Fee (MVF) Program.

The Blue Shield Board March 19 decided to delay action on its executive committee's recommendation after opposition was voiced officially to the proposed plan by The MSMS Council and by several county societies.

The MSMS Council at its meeting March 12 passed a motion "that The Council communicate with each member of the Michigan Medical Service (MMS) Board of Directors, reminding them that revocation of individual case participation would reverse the decision of the Board under the consent judgment, conflict directly with the policy of the medical profession, and adversely affect Blue Shield and its subscribers."

Before passing the motion, The Council had discussed the matter of per-case participation with John C. McCabe, MMS president, and Louis F. Hayes, M.D., MMS vice president for medical affairs.

Mr. McCabe reported that the MVF program plan did not originally include per-case participation because at that time MMS felt that paying reasonable charges both for participating physicians and non-participating physicians left no need for this payment provision. Full participation from all physicians was expected, he said, because it was felt the MVF program had all the ingredients to satisfy the profession.

However, continued Mr. McCabe, since then participation levels have not reached anticipated targets and in the past three months, former participation increases have stopped. Mr. McCabe said Blue Shield has no objection to physicians not participating, but simply felt that the company shouldn't have to be the collection agent for those physicians who choose not to participate. Blue Shield now gives little advantage to the participating physician and feels that there should be some distinction between participating and non-participating physicians.

Following the March 12 meeting, Ross V. Taylor, M.D., Council chairman, sent letters explaining The Council's action to all M.D. members of the Blue Shield Board and similar letters to all non-M.D. Blue Shield Board members.

In addition to The Council's action and Doctor Taylor's letters, letters of a similar nature were sent from the Wayne County Medical Society Council to the Blue Shield Board members, both M.D. and lay, and a similar resolution was adopted by the Bay-Arenac-Iosco County Medical Society.

MDA Annual Meeting May 14 In Ann Arbor

The annual meeting of the Michigan Diabetes Association will be held on Wednesday, May 14, at 6:30 p.m. at the Sheraton Motor Inn in Ann Arbor. Guest speaker will be Donnell D. Etzwiler, M.D., project director of the Diabetes Detection and Education Center of the Minneapolis-St. Paul area.

His topic will be "Knowledge is Health: The Minneapolis Way of Educating the Diabetic."

THE MICHIGAN HEALTH COUNCIL
and
THE UNIVERSITY of MICHIGAN
Department of Post Graduate Medicine

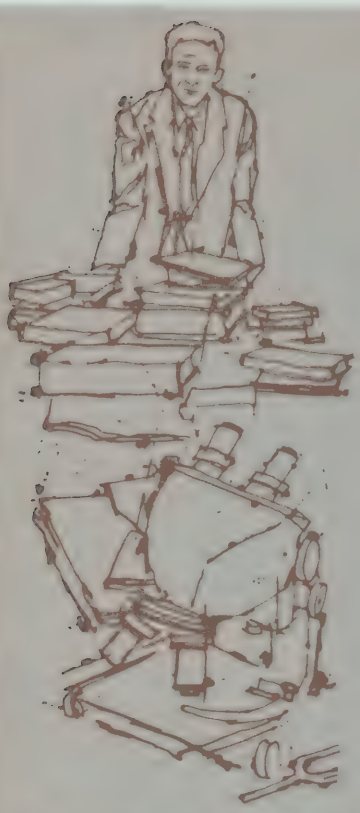
cordially invite you to participate in

THE MICHIGAN HEALTH CONGRESS

Wednesday, May 21, 1969
9 a.m. to 4:30 p.m.
at the new



TOWSLEY CENTER for CONTINUING EDUCATION in the HEALTH SCIENCES at the
UNIVERSITY OF MICHIGAN MEDICAL CENTER — ANN ARBOR



Seminar in Medical Education For Science And Education Writers

May 1, 1969

Kellogg Center
Michigan State University

Sponsored by

Michigan State Medical Society
Michigan State University
Michigan TB and Respiratory Disease Association

MSMS and two cosponsors will present a one day seminar at MSU, Thursday, May 1 to provide information about new developments in medical education at the three Michigan medical schools and across the nation for science and education reporters and editors.

Authorities from WSU, U-M and MSU will describe "what's new" at their schools in curricula, teaching techniques, etc.

The conference will climax with the annual Yates Lecture, presented each year by the Michigan TB and Respiratory Disease Association. William H. White, New York City, Editor of the new magazine, *Family Health,* accepted an invitation to discuss "Medical Communication — Public and Private" at the 4 p.m. lecture.

Reservations for the conference, cosponsored by MSMS, MSU and the TB Society, should be sent directly to Kellogg Center.

PROGRAM

Presiding: Brooker L. Masters, M.D., Chairman, Publication Committee, Michigan State Medical Society.

9:00 — Welcome
Andrew D. Hunt, Jr., M.D., Dean, College of Human Medicine, Michigan State

9:15 — The Tasks of Medical Education
Hilliard Jason, M.D., Ed.D., Professor and Director, Office of Medical Education Research and Development, Michigan State

10:00 — Coffee

10:15 — Recent Developments at the U-M Medical School
John Gronvall, M.D., Associate Dean, University of Michigan, School of Medicine

10:45 — Recent Developments at the WSU Medical School
Joseph Hess, M.D., Director of Research in Medical Education, Wayne State University, School of Medicine

11:15 — Roundtable
Panel of the three morning speakers; Moderator, Dean Hunt

12:00 — LUNCHEON (Guests of the sponsors)

1:30 — Buses to Giltner Hall

1:45 — Group divides:
½ to Giltner 111 — Demonstration of Doctor-Patient Relationship Program; ½ to Giltner 139 — Demonstration and Discussion of Self-Instructional Techniques

2:30 — Coffee and Visit Human Biology Labs

3:00 — Groups interchange between Giltner 111 and Giltner 139

3:45 — Buses back to Kellogg Center

4:00 — *YATES LECTURE*
William H. White, Editor, *Family Health,* New York City
Medical Communication — Public and Private

Registration Form
For Seminar in Medical Education
For Science and Education Writers

Return to Continuing Education Service
Michigan State University
East Lansing, Michigan 48823

NAME _____

ADDRESS _____

CITY _____ **COUNTY** _____

STATE _____ **ZIP** _____

_____ **Yes I will attend the Seminar May 1 and the Luncheon. The registration fee and the luncheon will be covered by sponsors of the conference.**

DO NOT SEND MONEY WITH THIS FORM

Thursday, May 8, 1969

Kellogg Center
Michigan State University
East Lansing, Michigan

1969 Conference On Medical Aspects of High School Sports

High school team doctors, coaches, trainers and school administrators will confer Thursday, May 8 at Kellogg Center, Michigan State University for the "Fourth Annual Conference on the Medical Aspects of Michigan High School Sports."

The registration fee will be covered by the conference sponsors. The luncheon will be $3.00.

* * *

9:00 a.m. to 9:30 a.m.

REGISTRATION, Conference Desk, Kellogg Center Lobby. (Coffee and doughnuts will be served)

9:30 a.m. to 9:45 a.m.

WELCOME AND TESTIMONIAL TO THE LATE MR. CHARLES E. FORSYTHE (Long time Director of the Michigan High School Athletic Association)

Gerald A. O'Connor, M.D., Ann Arbor; Chairman, Michigan State Medical Society Committee on Medical Aspects of Organized Athletics; Team Physician, University of Michigan

9:45 a.m. to 10:15 a.m.

PROTECTIVE EQUIPMENT FOR SPORTS

Department of Intercollegiate Athletics, Michigan State University, East Lansing

10:15 a.m. to 11:15 a.m.

CONDITIONING AND REHABILITATION OF THE KNEE

Fred L. Allman, Jr., M.D., Atlanta, Georgia; Orthopedic Consultant, University of Georgia and the Atlanta Public Schools Athletic Teams; President, American College of Sports Medicine

11:15 a.m. to 12:00 Noon

TAPING AND TRAINING PROCEDURES ESSENTIAL TO GOOD HIGH SCHOOL SPORTS PROGRAMS

William E. ("Pinky") Newell, R.P.T., West Lafayette, Indiana. Head Trainer, Purdue University; Former Executive Secretary, National Athletic Trainers Association

12:00 Noon to 1:15 p.m.

LUNCHEON

Speaker: "Duffy Daugherty, East Lansing. Head Football Coach, Michigan State

Topic: *"A FUNNY THING HAPPENED AT THE STADIUM"* OR *"WHEN IN DOUBT . . . TRY AN ON-SIDE KICK"*

1:30 p.m. to 2:00 p.m.

CONDITIONING AND WEIGHT MAKING PROGRAMS FOR WRESTLERS

Douglas Blubaugh, East Lansing. Assistant Wrestling Coach, Michigan State University; Gold Medal Winner, Wrestling, 1960 Olympic Games; Designated in 1960 as World's Outstanding Amateur Wrestler

2:00 p.m. to 2:45 p.m.

THE HIGH SCHOOL ATHLETE AND HIS EMOTIONS

W. Donald Weston, M.D., East Lansing. Assistant Professor of Psychiatry, College of Human Medicine, Michigan State University; Former Football Player, University of Southern California

2:45 p.m. to 3:00 p.m.

THE PHYSICIAN'S ROLE IN HIGH SCHOOL ATHLETICS

Allen W. Bush, Lansing. Director, Michigan State High School Athletic Association

3:00 p.m. to 4:00 p.m.

THE TREATMENT AND REHABILITATION OF SHOULDER AND ELBOW INJURIES IN ATHLETES

Fred L. Allman, Jr., M.D., Atlanta

4:00 p.m. to 4:30 p.m.

WIND-UP DISCUSSION. The answering of questions from the floor

Sponsored by

Michigan State Medical Society
Michigan State University
Student Health Service
College of Human Medicine
Continuing Education Service

REGISTRATION FORM

Return to: MEDICAL ASPECTS OF HIGH SCHOOL SPORTS May 8, 1969
Continuing Education Service
Michigan State University
East Lansing, Michigan 48823

NAME _____

ADDRESS _____

CITY _____ **COUNTY** _____

STATE _____ **ZIP** _____

I would like _____ ticket(s) for the luncheon on May 8. ($3.00 each) The registration fee will be paid by the sponsors of the conference.

I would like to reserve a room at Kellogg Center on the night of May 7 _____

Single _____ ½ Twin _____

Kellogg Center housing is $7.25 plus tax for a twin-bed room per person per night. The single rate is $10.50 plus tax per night. To accommodate the maximum number of conference guests, it may be necessary for you to share a twin-bed room with another member of your conference.

DO NOT SEND MONEY WITH THIS FORM



Members of the MSMS Committee on Mental Health met recently with several legislators to exchange opinions, questions and comments on current mental health and mental retardation problems in Michigan. Leaders of the committee, E. H. Rodda, M.D., Bay City, left, vice chairman and Benjamin Jeffries, M.D., Harper Woods, right, chairman, are pictured here with Sen. Alvin DeGrow, (R-Pigeon), second from left, and Sen. Arthur Cartwright (D-Detroit), second from right.

Symposium Includes MSMS Members

Three MSMS members are on the faculty for a symposium scheduled April 23 at Michigan State University titled "The Disturbed Person and The Community." It will run in conjunction with the Spring Mental Health Meeting April 24 of the Community Mental Health Association of Michigan, and the Association of Michigan Community Psychiatric Clinic Boards.

The symposium will be sponsored by the university, the St. Lawrence Community Mental Health Center and the Community Mental Health Association of Michigan.

MSMS MEMBER TO SPEAK AT SCHOOL NURSES' MEETING

Bruce L. Danto, M.D., of the Detroit Psychiatric Institute, an MSMS member, will address the annual conference of the Michigan Association of School Nurses, scheduled April 25 and 26 at the Michigan Education Conference Center at Battle Creek.

NEW APPOINTMENTS CHANGE AMA STAFF

Three recent top-level staff appointments have changed the make-up of the American Medical Association staff.

By a unanimous vote, the AMA Board of Trustees appointed Ernest B. Howard, M.D., to be the association's executive vice president. Doctor Howard had served as the AMA assistant executive vice president since 1948 and as acting executive vice president since September.

One of Doctor Howard's first official duties after his appointment was to speak at the Second Annual Conference for Health Planning and Related Subjects, sponsored by MSMS at Kalamazoo in April. Doctor Howard delivered the opening talk the first day of the two-day meeting. His topic was "Crystal Balling Federal Health Plans for 1969-70."

In the other two AMA staff changes, Jim Reed moved from director of the Communications Division to assistant to the executive vice president, and Charles S. Lauer became director of AMA's Communications Division.

LUNG CANCER SYMPOSIUM SET MAY 9 - 10

A Symposium on Lung Cancer will be sponsored May 9 and 10 by the Michigan Cancer Foundation and the Wayne State University school of Medicine. Sessions will be held at the headquarters of the Wayne County Medical Society in Detroit. Chairman of the meeting is V. K. Vaitkevicius, M.D., Director of the WSU Division of Oncology.

Discussion topics will include carcinogenicity of cigaret smoking, effects of cigaret smoking on bronchial epithelium, screening procedures, therapy, smoking centers, and endocrine syndromes accompanying lung cancer.

The first session will be opened by Alexander J. Walt, M.D., Associate Dean at the WSU School of Medicine, and Michael J. Brennan, M.D., President and Scientific Director of the Michigan Cancer Foundation.

Out-of-town speakers will be: Alvan R. Feinstein, M.D., Associate Professor of Medicine and Epidemiology, Yale University; Robert R. Shaw, M.D., Dallas, Spencer Payne, M.D., Mayo Clinic; Jonas Valaitis, M.D., Lutheran General Hospital, Parkridge, Illinois; Peter Peacock, M.D., Chairman of Public Health and Epidemiology, University of Alabama; Oscar Auerbach, M.D., Veterans Administration Hospital, East Orange, New Jersey.

CANCER FOUNDATION SCHEDULES CLINICS TO END SMOKING

Because April has been designated Cancer Control Month by President Nixon, the Michigan Cancer Foundation will sponsor three major smoking withdrawal clinics in the Detroit area.

The clinics will be held April 14-18 at the Henry Ford Museum Theater in Greenfield Village; April 21-25 in Parcells Junior High School, Grosse Pointe, and April 28 - May 2 in Providence Hospital, Southfield.

Medicine Religion Workshop May 8

The tentative program for the annual MSMS Medicine and Religion Workshop planned May 8 at MSMS Headquarters has been completed.

Led by Winslow G. Fox, M.D., MSMS Medicine-Religion Committee chairman, the 10 a.m. to 3 p.m. program will feature a presentation of the basic aims of the AMA medicine and religion program by Paul B. McCleave, LL.D., Chicago, director, AMA Department of Medicine and Religion.

Keynote speaker will be William N. Hubbard, Jr., M.D., Dean of the U-M School of Medicine, who will discuss "Gut Issues in Medical Ethics."

The program is tentatively scheduled as follows:

10:00 a.m. Opening, Welcome and Introductions by Doctor Fox
Presentation by Doctor McCleave

10:30 a.m. Reports by county medicine and religion committee chairmen

10:45 a.m. Presentation of new AMA film, "A Storm, A Strife," followed by discussion

noon Luncheon

1:30 p.m. Afternoon program including discussions on where doctors and seminaries can constructively meet, program projections, titles, topics and the use of media.

2 p.m. Doctor Hubbard

Med Schools Contribute Faculty To Spring PG Lectures

The Spring Postgraduate Lectures offered by MSMS for Michigan physicians' continuing education are led by doctors from the three medical schools.

Those participating in the 1969 series in April and May are, from the University of Michigan: T. J. Hermann, M.D.; O. G. Haig, M.D.; S. J. Behrman, M.D.; E. S. Tank, M.D.; J. G. Turcotte, M.D.; R. G. Hiss, M.D.; F. Bruce Fralick, M.D.; A. J. French, M.D.; W. J. Fry, M.D.; W. D. Robinson, M.D.; H. A. Towsley, M.D.; W. P. Work, M.D.; B. A. Bercu, M.D.; R. W. Bailey, M.D., and R. D. Judge, M.D.

Participants from Michigan State University are S. N. Swisher, M.D., and F. J. Haddy, M.D., while the Wayne State University instructors are Irwin Rosenberg, M.D.; Irwin J. Schatz, M.D.; H. E. Pederson, M.D., and A. M. Lerner, M.D.

The dates and places of the lectures are as follows:

April 4, Ottawa County, 4 p.m., Holland City Hospital
April 8, Port Huron, 6:30 p.m., Black River Country Club
April 24, Alpena, 5 p.m., Alpena General Hospital
April 30, Grayling, 6:30 p.m. Shoppenagons Inn
May 6, Calhoun County, 6:30 p.m., Schulers, Marshall
May 8, Petoskey, 6:30 p.m., Perry Davis Hotel
May 14, Livingston County, 5 p.m., McPherson Community Center, Howell
May 15, Midland, 2 p.m., Midland Hospital Association
May 19, Houghton, 3:30 p.m., St. Joseph Hospital
May 19, Sault Ste. Marie, 6:30 p.m., Ojibway Hotel
May 20, Lansing, 6:30 p.m., Jack Tar Hotel
May 20, Niles, 6:30 p.m., Pickwick Club
May 20, Escanaba, 4:30 p.m., St. Francis Hospital
May 20, Ironwood, 3:30 p.m., Grand View Hospital
May 20, Manistique, 12 noon, Schoolcraft Memorial Hospital
May 21, Iron Mountain, 3:30 p.m., Veterans Hospital
May 21, Menominee, 3:30 p.m., St. Joseph Lloyd Hospital
May 21, Muskegon, 1:30 p.m., Hackley Hospital
May 22, Marquette, 6:30 p.m., Holiday Inn
May 29, Cadillac, 4 p.m., Mercy Hospital

A National Health Council directory of films and publications on health careers is in the works, being planned and executed in part by the group below. From left, they are John A. Doherty, executive director of the Michigan Health Council and chairman of the National Health Council - Michigan Hospital Association Joint Council on Health Manpower's subcommittee to prepare the directory; Mrs. Jan Davidson, Indianapolis, executive director of The Indiana Health Careers, Inc.; Mrs. Monica V. Brown, executive director of the Health Careers Association of Greater Cincinnati; Mrs. E. C. Rowler, Monmouth, Ill., chairman of the AMA's Health Careers Committee; Mrs. Edwin Lake, Jackson, chairman of the Health Careers Clubs of Jackson County Health Careers Council, and John P. Hyde, coordinator of the Michigan Health Council's Health Manpower Program.



Mark Your Calendar Now...

104th ANNUAL
SCIENTIFIC SESSION
MICHIGAN STATE
MEDICAL SOCIETY
Detroit, October 1-2

William Beaumont Painting Donated To Hospital

An oil duplicate by artist William Loechel of a celebrated painting of William Beaumont, M.D., has been accepted for permanent display at Royal Oak's William Beaumont Hospital.

The painting, presented at a recent meeting of the hospital's board of trustees, depicts the pioneer Michigan physician with Alexis St. Martin, French-Canadian voyageur whose life Doctor Beaumont saved. Medical history was made by Doctor Beaumont's observations of the digestive processes through an opening into St. Martin's stomach which remained after an accidental gunshot wound healed.

The oil duplicate had been on display during the past season in the Michigan Health Council's Health Careers Mobile as the vehicle toured the state. The original of the painting is displayed each year during the tourist season in the William Beaumont Memorial Building on Mackinac Island, where Doctor Beaumont's observation took place.

Doctors Responding Well To Survey of PG Needs

On April 7, just three weeks after the mailing of a survey studying the attitudes of 1,600 Michigan physicians toward their postgraduate educational needs, 50 percent of the surveys had been filled out and returned.

The response, according to Anthony Riley, project co-director with Neal A. Vanselow, M.D., was "very good," considering the demands on the physicians. "I'm very optimistic about the success of the survey," continued Mr. Riley. "The physicians are cooperating as we ideally wanted them to."

Floyd C. Mann, Ph.D., is program director for the survey which is authorized and granted by the Michigan Association of Regional Medical Programs (MARMP) and drawn up by the Center of Research for the Utilization of Scientific Knowledge (CRUSK) at the University of Michigan.

The three Ann Arbor leaders in the project are hoping to have all the questionnaires returned by the 10th of June and are already readying the early arrivals for machine scoring. The analysis of the surveys is planned for July, August and September, with the written report on the results to be published in November.

According to Doctor Vanselow, the purposes of the study are to find what physicians' attitudes are toward the educational materials offered in Michigan from the universities and MSMS, to discover what the physicians would like to have offered in the future that is not available now, to define the pressures from work, families and finances that prevent some physicians from keeping up, as well as what factors motivate others to continue their educations.

The surveys were sent to a scientifically selected sampling of Michigan's physicians.

ADD IN MEMORIAM

Since deadline for the May issue of *Michigan Medicine,* the following news has been received:

William F. Peterson, M.D., Muskegon, 45, died March 1.

Frederick E. Dodds, M.D., Flint, 79, died Feb. 27.

Harry L. Buller, M.D., Manchester, Conn., formerly of Detroit, 76, died March 9.

James B. Beatty, M.D., Russellville, Ala., formerly of Coldwater, 34, died Feb. 26.

Leland P. Shipp, M.D., Battle Creek, 64, died March 2.

Charles Ornstein, M.D., Southfield, 63, died March 20.

Second Class Postage Paid at Lansing, Mich.

Michigan Medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at Lansing, Michigan. Yearly subscription rate, $9.00. Printed in USA. All communications should be addressed to Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.
© 1969 Michigan State Medical Society.
Phone: Area Code 517, 337-1351.

MJ
NATL LIBR OF MEDICINE
8600 WISCONSIN AVE
BETHESDA 14 MD 20014

WI
MI 225

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

MAY 1969 • VOLUME 68 • NUMBER 9







NATIONAL LIBRARY OF MEDICINE
RECD. MAY 19 1969
INDEX
INPUT

JTC: MX2
INDEXER:
VOL-ISS: 68-9
DATE:
DEPT:
NON-
RUSH:

This May Issue in Commemoration of Michigan Week Offers a Special Series of Articles by Governor Milliken and Michigan Authorities in the Fields of Health and Medicine And All the Other Usual Sections, Too

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

- LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.
- Literature on indications and dosage available on request.
- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

MAY, 1969 • VOLUME 68 • NUMBER 9

See Table of Contents
For This Issue, Page 457

Michigan AFL-CIO Chief Testifies Against Legislation Supporting DO School Now

BY M. A. RILEY
MSMS LEGISLATIVE COUNSEL

Making it crystal clear that he was speaking for the giant union of which he is president, August Scholle of the Michigan AFL-CIO presented outspoken testimony recently opposing legislative support of an osteopathic college in Michigan until the present medical schools have reached their full potential.

Mr. Scholle, in a lengthy statement March 26 before the Michigan House of Representatives Appropriations Committee, expressed great concern about the shortage of funds for support of Michigan's elementary and secondary schools, many of which face a financial crisis. Pointing to a shortage of funds throughout the educational system he also underlined the failure of many millage proposals in Michigan communities.

Stating that the expenditure of a large amount of taxpayers' money might "sidetrack completely what we could develop in the expansion of a two-year to a four-year medical school at Michigan State," Mr. Scholle questioned the reason for some to insist, year after year on a state-supported osteopathic college. As to Doctors of Medicine and Doctors of Osteopathy, Mr. Scholle testified, he was aware of "no real distinction."

Mr. Scholle endorsed the offering of an optional degree in osteopathy to those students at the University of Michigan Wayne State University and Michigan State University who might desire it. Deploring the fact that the universities had made such an offer but that it seemingly had been rejected, he pointed out that all three present medical schools were capable of increasing their current enrollments, as well as offering the optional degrees.

In view of the cost involved to build a completely new osteopathic college, the optional degree offer, the similarities between modern M.D. and D.O. education, and the present urgent needs for tax expenditures in other areas, according to Mr. Scholle, the premise upon which the osteopathic school request is being made is "absolutely absurd."

"When these universities that we now have established have no longer any possibility of expansion," Mr. Scholle concluded, "I assure you that I will come here and advocate the establishment of another university, and I don't care whether you call it a D.O. university or an M.D. university. But until that time, don't impose an additional tremendous imposition on the backs of the working class of the people of this State who are presently inequitably overburdened with taxation now," he said.

Three key men in the planning of the 1969 Michigan State Medical Society Annual Session, are, from left, H. A. Towsley, M.D., Ann Arbor, chairman of the Committee on Friendship; Alexander J. Walt, M.D., Detroit, chairman of the Program Committee and James J. Lightbody, M.D., Detroit, MSMS president and chairman of the Planning Committee. The planning committee recently held its first meeting in Detroit. The Annual Session is scheduled Sept. 28 to Oct. 3 at the Sheraton-Cadillac Hotel in Detroit.



(Editor's Note: Final pages for this May issue of MICHIGAN MEDICINE went to press on April 28 as physicians and many others continue to voice their opposition to Senate Bill 70 and Substitute House Bill 2196 which propose to establish an osteopathic school as a state institution of higher education financed and maintained by the State of Michigan. The Page 451 article in this blue News Extra reports the opposition of Michigan AFL-CIO President August Scholle to the proposal. MSMS, in opposing an osteopathic state college, has declared that all three present medical schools and any future medical schools should offer students the option of either the MD or DO degree. The following article from the April issue of the Oakland County Medical Society BULLETIN suggests the possibilities of developing a new medical center in the Oakland County area.)

Discusses Possibilities of "An Oakland University College of Medicine"

BY RODMAN C. JACOBI, M.D.
OXFORD

Exciting ideas and positive contributions to medicine are emerging from the seemingly ageless and somewhat foreboding structures on the 800 acres of Pontiac State Hospital.

Heretofore thought of only as an institution for the routine domiciliary care of the mentally ill, a completely new concept of its present and future function has been evolving since 1965. The significance is such that we should pause and consider carefully before generating undue enthusiasm for the new plan to join Ford Hospital and the University of Michigan Medical School in a training program to produce more physicians.

Although not the only individual involved in the beginnings of the Pontiac State Hospital development, Donald Dawson, M.D., Director of Medicine and Surgery, has been the catalytic agent. Young, vigorous, and a motivator of all with whom he works, he has also been capable of envisioning a far-reaching concept for Oakland County and Michigan medicine that would ultimately do more than any other plan now in the works.

He explains that, in the beginning, increasing difficulties faced by community hospitals in Oakland County with regard to resident training led to consideration of using the abundant clinical material in "the pile of bricks" at his hospital to upgrade their training programs. So successful has the implementation of this idea been that the AMA and the Joint Commission on Accreditation have already given their full approval.

Specifically, a central surgical program was developed in conjunction with the four largest community hospitals in Oakland County. Pontiac State facilities and clinical material were utilized by residents on a rotating basis under the direct supervision of their own department chiefs. In addition, the research facilities of the Pontiac Medical Science Laboratories, Incorporated, located on the Pontiac State Hospital grounds, were made available to the trainees. Didactic lectures by area specialists and nationally known medical people were also instituted. Names like Dragstedt, Wangensteen, Hufnagel and Ellison have already been on the scene to contribute — with more to come on a regular basis.

Doctor Dawson hastens to explain that this is only a beginning and that he has hopes of broadening the scope as soon as possible to include all other major areas of medicine. Organization of a surgical program is only the first step.

FURTHER DISCUSSION with Donald Martin, M.D., Medical Superintendent of Pontiac State Hospital, reveals that this whole new development has occurred with his blessing and encouragement as well as that of the Department of Mental Health in Lansing. In their view, there can be nothing but benefit for the state hospital system in terms of improved medical and surgical care for its patients. Evidence to date certainly corroborates this feeling.

The rationale behind this whole idea relates to the disappearance of indigency in the population due to increased prosperity and government programs. Medical centers have been suffering because of this deficiency and their output of physicians has been limited proportionately. The need for affiliation between Ford Hospital and the University of Michigan Medical School is a case in point. Unfortunately, such a liaison can never achieve what can be done with Pontiac State Hospital. Its patient census averages 1800 and it is the central treatment facility for 18,000 mental patients in hospitals all over the state. In addition, there is a modern-day turnover of patients about every sixty days, due to improved treatment concepts, which multiplies what is already a vast potential. Both Doctors Martin and Dawson see almost unlimited opportunity for doctors, patients and medical education right here under our noses.

What might all this mean to Oakland County and Michigan medicine? It could be the logical beginning of a new medical center that would provide efficient, quality physician education. The success already achieved indicates that only further planning and organization is needed to include all major fields of medicine. Four large community hospitals, an active staff of 180 consultants from every specialty and the giant assets

Medical, Health Foundation Elects Officers, Sets Policy

At the recent annual meeting of the Michigan Foundation for Medical and Health Education, new officers were elected and a policy on grants was adopted.

Earl I. Carr, M.D., Lansing, long-time president, was named president-emeritus, while Harry A. Towsley, M.D., Ann Arbor, succeeded him as president. H. H. Gardner, M.D., Birmingham, treasurer, and Warren F. Tryloff, East Lansing, secretary, were re-elected.

T. N. Evans, M.D., and G. Thomas McKean, M.D., both of Detroit, were re-elected for three-year terms on the board, which met concurrently with the Foundation. A. Stewart Kerr of Detroit was named to the board for the term expiring in 1970. He succeeds J. E. Wolfram, of Lansing, who resigned.

The Foundation decided that the most efficient method of making loans to medical students would be through the three university student aid committees rather than directly by the Foundation itself as in the past. Future grants will be made to the student aid committees with the suggestion that the money be used by them to provide loans to medical students.

Distribution of income from the Bruce Fund, administered by the Foundation, was made in the amounts of $150 to Saginaw Hospital Council for hospital libraries and just over $4,000 to the University of Michigan to sponsor a pediatric fellowship fund.

Planning for BSIS Symposium Further Along

Plans are proceeding for the seventh national Biomedical Sciences Instrumentation Symposium which will be one of the highlights of the 100th anniversary of University Hospital at the University of Michigan.

A call is still being issued for papers to be presented at the four-day meet May 19-22 at Chrysler Center, the U. of M. "Imagery in Medicine" is the theme. Doctors interested in obtaining a list of the 17 subjects to be discussed may write to 1969 BSIS Technical Program Committee, c/o Ernest E. Sellers, BSIS Host Chairman, Box 618, Ann Arbor, Mich.

PONTIAC STATE HOSPITAL, CONT.

of Pontiac State Hospital are a formidable start.

WHAT MAJOR new ingredient is needed? We already have Oakland University and the excellence of its undergraduate education. Why not build a new medical school in conjunction with this high quality institution? Everyone agrees that there is a need; there only remains a decision about the mechanism of producing more doctors for Michigan. Osteopaths in the state have already developed plans for a school in Pontiac and use this same need as an argument for legislative funds to complete its development.

Most would agree, however, that the trained clinicians, quality hospital facilities and adequate clinical material simply are not available to them in this area. The legislature should have many second thoughts before approving money for that purpose.

An Oakland University College of Medicine, then, could be a reality based on circumstances as they now exist. Will it come to pass? Only time, the state legislature and the wisdom of medical people will tell the tale. As Doctor Dawson says, "We need more cohesion, more getting together and a desire to eliminate wasteful duplication of effort and facilities to make this thing go." In any event, a whole new medical complex would be a dramatic accomplishment if it comes from an idea born in "a pile of bricks" at Pontiac State Hospital.

Health Congress Set May 21 At U-M

A two-phase program on health manpower and critical health education problems is planned for the Michigan Health Council's annual Michigan Health Congress May 21 at the Towsley Center for Continuing Education in the Health Sciences, The University of Michigan.

Gov. William G. Milliken has been invited to speak at the all-day meeting, which will begin with registration at 9 a.m. and conclude at 4:30 p.m.

Keynote speakers will be William N. Hubbard, Jr., M.D., dean of the U-M School of Medicine, who will discuss medical and health manpower, and State Rep. Dale Warner, (R-Eaton Rapids), chairman of the House Special Committee on Narcotics.

Appearing with Doctor Hubbard in the health manpower phase of the program will be Harry A. Towsley, M.D., Ann Arbor, director of continuing medical education at Towsley Center, and E. Gifford Upjohn, M.D., Kalamazoo, chairman of the board of The Upjohn Company.

Representative Warner will detail three bills he introduced in the House of Representatives to bring all health education resources into the Department of Education, to give authority to judges and prosecutors, to provide a variety of sentences for sellers of narcotics, and to create a drug dependency and abuse program within the State Department of Public Health.

Doctor Cain Appointed

Waldo L. Cain, M.D., MSMS member from Detroit, was appointed recently by Gov. William G. Milliken to the state's Judicial Tenure Commission.

MAP Congress Passes Six Resolutions Bearing On Service of Professionals

Six resolutions bearing on the service of professionals were adopted by the MAP Congress April 11 in Lansing.

MAP adopted a resolution advancing public support of crime prevention. In part the resolution declared: "Neither the professions nor the public are fully aware of the deteriorating situation, particularly as it is evolving from drug abuse," therefore MAP voted "to offer space in its publications and time on its television and radio programs to advance public knowledge re the potential remedies for crime in Michigan."

Professional people were urged in a resolution to serve in the legislature. The MAP Congress expressed to the Legislature its "admiration for the caliber of its work and the dedication of its membership," and voted to "urge its individual members to stand for election to the Legislature, and its separate State Organization Members to support enthusiastically and financially those members of their ranks who will so stand."

MAP delegates recognized the "continuing need for excellence in our universities on the part of their undergraduate, advanced graduate, teaching and research personnel," and voted "that the Michigan Legislature be apprised of the MAP position that priorities for financial support of higher education should begin with the professional and advanced graduate schools."

Another resolution pointed out that "demagogue" attacks on the professions "can cause irreparable harm to the persons being served by those professions so irresponsibly attacked." MAP delegates instructed "that the MAP Legislative Committee seek to have resolutions passed which would declare it to be public policy that prior to the publishing of such attacks the affected profession through its state association be given an opportunity to act to mitigate the alleged fault or, failing that, to render such explanations as it feels are called for."

MAP delegates noted "that the development of self-government under an exemplary code of ethics is a desired goal of all professions," and recommended "that MAP request its members to approve and urge the passage by the Michigan Legislature of a Professional Practices Act which will accomplish this purpose for the teaching profession."

MAP voted "to resist any effort made by any person or body which would have as its purpose the placing of a non-professional on the professional licensing or standard-setting board of or for the professions." The resolution declared that "under the high professional standards established and enforced by the professional societies of Michigan, the major professions of this state have risen to new highs of scientific accomplishments and service." In describing the kinds of people who should serve on licensing boards, the resolution explained that "for any person to so represent the public, either in private organization or public board, the educational background and scientific expertise of a member of the profession being licensed is needed."

CONGRESS HIGHLIGHTS AWARDS, ELECTIONS

Presentations of awards to distinguished persons and the election of members to the Board of Directors were highlights of the recent annual Michigan Association of the Profession's annual Congress of the Professions in Lansing.

Award winners at the annual meeting April 11 were Harry A. Towsley, M.D., Ann Arbor, nationally-known medical educator, pediatrician and civic leader, who received the MAP Distinguished Award; John A. Hannah, newly-appointed director of the Agency for International Development and former president of Michigan State University for 28 years, MAP Outstanding Service Award, and Gilbert Saltonstall, M.D., Charlevoix, Past President's Award.

Named to the Board of Directors were Henry L. Homan, D.D.S., Grand Rapids; John W. Cummiskey, J.D., Grand Rapids; Ray H. Lawson, M.A., Rochester; Edwin H. Young, P.E., Ann Arbor, and George W. Slagle, M.D., Battle Creek, who represent, respectively, the professions of dentistry, law, education, engineering and medicine.

Doctor Slagle and Doctor Saltonstall are both former presidents of MSMS.

Michigan Speakers To Talk May 22 At Wayne Clinic

Speakers for the Wayne State University School of Medicine Alumni Association's annual Clinic Day and Alumni Reunion include five Michigan doctors. Their talks will center on the theme "Drug Abuse."

The event is scheduled May 22 at the Sheraton-Cadillac Hotel, Detroit, and will include a scientific program, the association's annual meeting and a complimentary luncheon.

Out-of-state speakers will be Duke D. Fisher, M.D., staff psychiatrist at the Naval Hospital in Oakland, Calif., "LSD and the Hallucinogens"; Neil L. Schayet, LL.B., practicing attorney with the firm of Chayet and Flash in Boston, "Medicolegal Aspects of Drug Abuse," and Lawrence Brilliant, M.D., Detroit, associate editor of *New Physician*, "Marijuana: Advice to Parents."



JAMES J. LIGHTBODY, M.D.
PRESIDENT, 1968-69

Michigan Medicine Salutes Michigan Week

The special articles in this issue of *Michigan Medicine* appear in connection with Michigan Week, to be observed May 17-24. The articles were sought by the Publication Committee to provide MSMS members with new information and insights in many aspects of health care and medical education in our state.

Michigan Week again presents physicians and their professional societies with excellent opportunities to focus on a number of medical concerns.

THERE ARE MANY WAYS in which the county medical societies can take the initiative in Michigan Week. The MSMS Committee on Public Relations and staff stand by ready to assist in any promotional, educational efforts.

Saturday, May 17 will be observed as "Community Pride Day." Physicians are urged to join other community leaders to let the world know that Michigan's welcome mat is out! Let the foreign-trained physicians and medical students from other states know they are welcome in Michigan.

Sunday, May 18 will be observed during Michigan Week as "Spiritual Foundations Day" as the time to review the great history and heritage of religion in Michigan. MSMS and more and more counties are carrying out joint medicine-and-religion projects.

THE VOLUNTARY COOPERATION of medicine with government can be developed in speeches, etc., on Monday, May 19, "Our Government Day." Many physicians serve on various governmental boards and will take advantage of the day to help focus attention on urban renewal, long range area development, suburban planning, river improvement, safety programs, air and water pollution programs, etc.

The rich heritage of medicine in Michigan will be in the spotlight on Tuesday, May 20 when Michigan Week features "Our Heritage Day." County medical societies can point to historical accomplishments and also stress the current needs for more physicians and health workers through hospital open house programs, lectures, tours, etc.

THE CONTRIBUTIONS OF physicians to the health of the community can be featured in newspapers, etc., on Wednesday, May 21, which will be observed during Michigan Week as "Our Livelihood Day." A possible project to help develop the hospitality theme for 1969 would be for the county medical society to host school counselors at a luncheon to help explain the need for more physicians and health teammates.

On "Education Day," Thursday, May 22, physicians and medical societies might wish to recognize local educators who do an outstanding job in teaching science or in counseling young people to consider careers in medicine.

Friday, May 23 is the annual "Hospitality Day." The community might be encouraged to officially welcome all new physicians in the community during the past year; or the county medical society might have a luncheon to officially welcome the new businesses and industries to the community — or the new men in the other professions.

THE FRIENDLY COUNTY medical society can use "Our Youth Day," Saturday May 24 to sponsor a luncheon to honor the young people accepted for 1969 medical school classes, or can salute the lads in the Medical Explorer troop, or can thank the young candystripers at the hospital.

MSMS is proud to cooperate with the many other groups promoting Michigan Week . . . and we believe this May issue of *Michigan Medicine* is a fine contribution. We thank the special contributors.

PRESIDENT'S PAGE



He is elderly, he is on corticosteroids, when he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given the drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company
Pearl River, New York

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by Michigan Medicine. Michigan Medicine will pay the first $25 of the engraving bill, and the authors shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.

6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.

7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

8. Articles should ordinarily be less than four printed pages in length (3000 words).

9. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

10. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

IN THIS ISSUE

MICHIGAN WEEK ARTICLES

469 Governor Views Today's Medicine; William G. Milliken
470 Report from Michigan Department of Public Health; R. G. Rice, M.D
471 Status of Mental Health Department; William H. Anderson, M.D.
473 Health Council Expands Staff; John A. Doherty
475 U-M Geared for Expansion; William N. Hubbard, Jr., M.D.
476 WSU School of Medicine Growing; Ernest Gardner, M.D.
477 MSU Human Medicine College Moving Ahead; Andrew D. Hunt, Jr., M.D.
479 Comprehensive Health Planning Accelerating; Andrew D. Hunt, Jr., M.D.
481 MARMP Gains Momentum; Albert E. Heustis, M.D., M.P.H.
482 Hospital Association 50 Years Old; Allan Barth
484 Michigan Nurses Observe Anniversary; Mrs. Joan S. Guy, R.N.

SPECIAL ARTICLES

486 Maternal Welfare Conference Successful; Judith Marr
523 Report on Visit to Guam; R. Craig Barlow, M.D.
538 Consumerism in American Economy; C. T. Hardwick, Ph.D.
540 California Medical Society-OEO Project

BIRCH SOCIETY'S ATTACK ON SEX EDUCATION ANSWERED BY THREE MSMS MEMBERS, PAGES 518-522

PRESIDENT'S PAGE

455 Michigan Medicine Salutes Michigan Week

PHOTO SECTION, Pages 487-494

OTHER FEATURES

451 Breaking News
460 Our State Society
461 Committee Calendar
465 Extract of Council Minutes
466 Michigan Mediscene
485 Monthly Surveillance Report
501 Ancillary
513 Editorial Views
525 Legal
535 New Members
536 County Societies
544 MSMS Members in the News
546 Index to Scientific Articles
547 In Memoriam
550 Notes and Quotes

The Michigan Week cover was designed by Dar Davis, art instructor at Douglas, Michigan.

Michigan Medicine

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at Lansing, Michigan. Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351.

© 1969 Michigan State Medical Society.

a message that concerns one doctor in 20...

As you may appreciate, converting to MVF and coping with the growing pains of a constantly expanding enrollment have created problems for Blue Shield. Yet, considering the difficulties involved, many people would think we're doing pretty well in promptly processing 95 per cent of the 35,000 claims we receive from M.D.'s and D.O.'s every day. But, we're not satisfied. And neither are you, if you're one of the five per cent who has had to wait for payment.

If you're this one in 20, please bear with us. We're trying our best to make sure you receive your payment as soon as possible.

With your cooperation, we'll soon be doing better.

MICHIGAN BLUE SHIELD



MICHIGAN STATE MEDICAL SOCIETY

120 West Saginaw (P.O. Box 152)
East Lansing, Mich. 48823
Area Code 517, 337-1351

1010 Antietam Road
Detroit 48207
Area Code 313, 965-0541

PRESIDENT	James J. Lightbody, M.D.	Detroit
PRESIDENT-ELECT	Robert J. Mason, M.D.	Birmingham
SECRETARY	Kenneth H. Johnson, M.D.	Lansing
ASST. SECRETARY	Brooker L. Masters, M.D.	Fremont
TREASURER	John R. Ylvisaker, M.D.	Pontiac
ASST. TREASURER	C. Allen Payne, M.D.	Grand Rapids
SPEAKER	James B. Blodgett, M.D.	Detroit
VICE-SPEAKER	Vernon V. Bass, M.D.	Saginaw
PAST PRESIDENT	Bradley M. Harris, M.D.	Ypsilanti
COUNCIL CHR.	Ross V. Taylor, M.D.	Jackson
VICE-CHAIRMAN	Ralph R. Cooper, M.D.	Detroit

COUNCILORS:

Sidney Adler, M.D.	1st	Detroit
Ralph R. Cooper, M.D.	1st	Detroit
Don W. McLean, M.D.	1st	Detroit
Milton R. Weed, M.D.	1st	Grosse Pointe Park
Robert K. Whiteley, M.D.	1st	Detroit
Ross V. Taylor, M.D.	2nd	Jackson
Harvey C. Hansen, M.D.	3rd	Battle Creek
Don Marshall, M.D.	4th	Kalamazoo
John R. Pedden, M.D.	5th	Grand Rapids
Harold H. Hiscock, M.D.	6th	Flint
John J. Coury, M.D.	7th	Port Huron
A. Carl Stander, M.D.	8th	Saginaw
Robert V. Daugharty, M.D.	9th	Cadillac
Edward H. Rodda, M.D.	10th	Bay City
Brooker L. Masters, M.D.	11th	Fremont
Wm. A. LeMire, M.D.	12th	Escanaba
J. Robert Franck, Jr., M.D.	13th	Wakefield
Harold F. Falls, M.D.	14th	Ann Arbor
Sydney Scher, M.D.	15th	Mt. Clemens

EXECUTIVE DIRECTOR	Hugh W. Brenneman	East Lansing
ASSOCIATE EX. DIR.	Warren F. Tryloff	East Lansing
GENERAL COUNSEL	Lester P. Dodd	Detroit
LEGAL COUNSEL	A. Stewart Kerr	Detroit
ECON. CONSULTANT	Clyde T. Hardwick	Detroit
HISTORIAN	Wm. J. Stapleton, Jr., M.D.	Detroit
ASS'T HISTORIAN	Wm. M. LeFevre, M.D.	Muskegon

SCIENTIFIC EDITOR
John W. Moses, M.D., Detroit

EXECUTIVE EDITOR
Herbert A. Auer

MANAGING EDITOR
Judith Marr

ASSOCIATE SCIENTIFIC EDITORS
Frederick J. Cady, Jr., M.D., Surgery
Saginaw
Robert M. Daugherty, M.D., Basic Science
East Lansing
Harold E. De Pree, M.D., Medicine
Kalamazoo
Dean C. Elliott, M.D., Otolaryngology
Petoskey
Tommy N. Evans, M.D., Obst.-Gyn.
Detroit
Dorin L. Hinerman, M.D., Pathology
Ann Arbor
Samuel D. Jacobson, M.D., Medicine
Detroit
Benjamin Jeffries, M.D., Psychiatry
Detroit
Raymond S. Kurtzman, M.D., Radiology
Detroit
A. Martin Lerner, M.D., Medicine
Detroit
George H. Lowrey, M.D., Pediatrics
Ann Arbor
Carl A. Moyer, M.D., Surgery
Baraga
Charles E. Parkinson, M.D., Radiology
Battle Creek
John C. Pierce, M.D., Medicine
Grand Rapids
Frank H. Power, M.D., Surgery
Traverse City
J. G. Turcotte, M.D., Surgery
Ann Arbor
Alexander J. Walt, M.D., Surgery
Detroit
Park W. Willis, III, M.D., Medicine
Ann Arbor
Richard E. Wunsch, M.D., Medicine
Traverse City

Publication Committee

Brooker L. Masters, M.D.
Harvey C. Hansen, M.D.
William A. LeMire, M.D.
Don Marshall, M.D.
Don W. McLean, M.D.
Edward H. Rodda, M.D.
Milton R. Weed, M.D.

County Medical Societies Alerted To Proper Emergency Highway Service

The MSMS Committee on Highway Injury urges all appropriate chairmen of county medical societies to forward the following information to all city or county governments involved in the problem of providing proper emergency highway service. Ambulance companies and the funeral homes also should be contacted.

The Highway Safety Act of 1966 directs the states to "Design highway safety programs that will reduce traffic accidents, death, injuries and property damages resulting therefrom." Standards promulgated by the U.S. Secretary of Transportation specifically include the development of emergency medical services and is a component in the Michigan Comprehensive Highway Safety Plan.

Local communities, faced with the need to develop or expand emergency ambulance service, may apply for and receive some subsidy under the provisions of the Act. Safety highway funds can be used to participate to the full 50% level in purchasing equipment if a new service is initiated. When a service already exists in a community, it is possible that highway safety funds can be used to participate in purchasing additional equipment to expand or improve the service at the local level. Funds are also available to pay 50% of the cost involved to train ambulance drivers and attendants.

After the first year of operation of a project in which highway safety dollars have been used in purchasing equipment, depreciation costs cannot be included as a participating cost in the project. If a project is continued, considering that no additional equipment will be purchased, the only participation eligible would be that percentage of highway response related to operating costs that can be identified.

(The above article was necessarily briefed from material provided by the Office of Highway Safety Planning, Second Floor, Lewis Cass Building, Lansing, Michigan. Additional information can be obtained by contacting this state agency.)

DOCTOR SWEENY LEADS AMA DELEGATION

D. N. Sweeny, Jr., M.D., Detroit, is new chairman of the Michigan Delegation to the AMA. He was elected at a recent caucus when Otto K. Engelke, M.D., Ann Arbor, was elected vice chairman and J. C. Danforth, Jr., M.D., Grosse Pointe Woods, was selected treasurer. Luther M. Leader, M.D., Royal Oak, is retiring chairman.



OUR STATE SOCIETY

DOCTOR McCORVIE ATTENDS NATIONAL CONFERENCE

Donald McCorvie, M.D., Williamston, new chairman of the MSMS Committee on Rural Medical Service, represented the Society at the 22nd National Conference on Rural Health March 21-22 in Philadelphia. The conference featured two symposiums, "Health Manpower for the Changing Rural Community," and "Changing Methods in Delivery of Rural Health Care."

MSMS Names Liaisons to Three Medical Schools

MSMS has officially established liaisons with the SAMA chapters in all accredited Michigan medical schools, according to a 1968 resolution referred to The Council by the House of Delegates.

The three liaisons are C. Howard Ross, M.D., of Ann Arbor, liaison to the University of Michigan SAMA chapter; Norman D. Henderson, M.D., East Lansing, to the Michigan State University chapter, and James M. Pierce, M.D., Detroit, to the Wayne State University chapter.

COMMITTEE CALENDAR

Every month many MSMS committees meet to develop new projects and to move along activities approved by The Council or suggested by the House of Delegates. Following is a calendar of April, May and future meetings for The MSMS Council, MSMS committees and other official groups.

Tuesday-Wednesday, April 1-2
Liaison Committee with Michigan Chapter, Health Insurance Council
New Center Motor Lodge, Detroit
Chairman: John J. Coury, M.D., Port Huron

Wednesday, April 2
MSMS Committee on Cardiac Disease
MSMS Headquarters, East Lansing
Chairman: Sidney E. Chapin, M.D., Dearborn

Wednesday, April 9
MSMS Committee with State Bar of Michigan
Sheraton-Cadillac Hotel, Detroit
Chairman: Orlen J. Johnson, Bay City

Wednesday, April 9
Committee on Alcohol and Drug Dependence
MSMS Headquarters, East Lansing
Chairman: Herbert A. Raskin, M.D., Southfield

Wednesday, April 23
MSMS Committee to Study Health Problems Of Disadvantaged in the Cities
Wayne County Medical Society Headquarters, Detroit
Chairman: Frank B. Walker, M.D., Grosse Pointe

Wednesday, April 23
MSMS Committee on Respiratory Diseases
MSMS Headquarters, East Lansing
Chairman: Richard A. Rasmussen, M.D., Grand Rapids

Thursday, April 24
Committee on Medical Aspects of Organized Athletics
MSMS Headquarters, East Lansing
Chairman: G. A. O'Connor

Thursday, April 24
Committee on Nursing
MSMS Headquarters, East Lansing
Chairman: R. L. Tupper, M.D., Pontiac

Thursday, April 30
MSMS Council
MSMS Headquarters, East Lansing
Chairman: Ross V. Taylor, M.D., Jackson

Thursday, April 30
Judicial Commission
MSMS Headquarters, East Lansing
Chairman: Donald V. Sweeny, Jr., M.D., Detroit

Thursday-Sunday, May 1-4
MSMS Committee on Emergency and Disaster Medical Services
Sheraton-Cadillac Hotel, Detroit
Chairman: Charles P. Anderson, M.D., Detroit

Wednesday, May 7
MSMS Committee on Cancer
MSMS Headquarters, East Lansing
Chairman: M. E. Dodds, M.D., Flint

Wednesday, May 7
Michigan Cancer Coordinating Committee
MSMS Headquarters, East Lansing
Chairman: C. Fred Arnold, Detroit

Wednesday, May 14
MSMS Committee on Emergency and Disaster Medical Services
Sheraton-Cadillac Hotel, Detroit
Chairman: C. P. Anderson, M.D., Detroit

Wednesday, June 4
MSMS Council
MSMS Headquarters, East Lansing
Chairman: Ross V. Taylor, M.D., Jackson

Thursday-Saturday, July 31 - Aug. 2
MSMS Midsummer Session of The Council
Boyne Mountain Lodge, Boyne Falls
Chairman: Ross V. Taylor, M.D., Jackson

Wednesday, Oct. 1
MSMS Council
Sheraton-Cadillac Hotel, Detroit
Chairman: Ross V. Taylor, M.D., Jackson

SUBTLE SEDATION

Solfoton

Sedation without peaks and valleys

REMOVES THE MENTAL BLUR
THAT CLOUDS VISION

CONSTRUCTIVE THERAPY—Solfoton in any form taken at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Each tablet or capsule contains:

PHENOBARBITAL (Warning: may be habit forming) ... 16 mg.
BENSULFOID® (See P.D.R.) ..... 65 mg.

Precaution: same as 16 mg. phenobarbital

Literature and clinical supply available to physicians.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

AVAILABLE

SOLFOTON ..... (yellow, uncoated tablets "P")
100s, 500s, 5000s
SOLFOTON CAPSULES ..... (yellow and brown)
100s, 500s, 1000s
SOLFOTON S/C ..... (sugar-coated, beige tablets)
100s, 500s, 4000s

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Solfoton®

SUBTLE SEDATION


It takes more than a pill
to lose weight

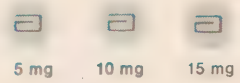
That's why Abbott's got what it takes–
a pill and a program for each patient

THE PRODUCT–5 Different Strengths

For smooth appetite control plus mood elevation

Desoxyn® Gradumet®

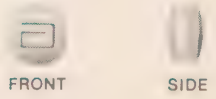
Methamphetamine Hydrochloride in Long-Release Dose Form



For patients who can't take plain amphetamine

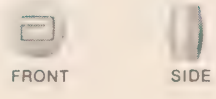
Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride, 60 mg. Sodium Pentobarbital



Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride, 90 mg. Sodium Pentobarbital



THE PROGRAM–3 Patient Booklets



Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably —and permanently. Food exchanges and a comprehensive list of foods, showing their calories, are also included.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

Compact new booklet features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

902110

ABBOTT

Please see Brief Summary on next page.

Ask Your Abbott Man For Patient Supplies.

BRIEF SUMMARY

Desoxyn® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates, or in those with history of manifest or latent porphyria.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Because of its sodium pentobarbital content, use Desbutal with caution in patients receiving coumarin anticoagulants. Pentobarbital may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

902110

ABBOTT

a modest investment equips your office for a wider range of patient services Consider how the Burdick **MW-200 microwave diathermy unit** can help your patients — up to 7.81° F. temperature increase five cms. deep in muscle tissue. Increases blood flow, vasodilatation and venous return in normal tissue. Simple to operate, with no tuning, no applicator-to-skin contact, no toweling. Consider how the Burdick **UT/4300 ultrasound-electrical stimulation unit** can help identify myalgic trigger-point areas quickly and simply. Either ultrasound or stimulation can be used separately or in combined therapy technic. Take a good look at your present equipment. Then contact your Burdick dealer or write The Burdick Corporation, Milton, Wisconsin 53563 for full details.

ultrasound - stimulation UT/4300



microwave diathermy MW-200

BURDICK

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit, Michigan 48201
Telephone: TEmple 2-4444

Extract of MSMS Council Minutes

Meeting of March 12, 1969

The Council received reports from MSMS representatives who attended the AMA Joint Commission on Accreditation of Hospitals and AMA Conference on Medical Education held in Chicago, and the meeting of the United States Chamber of Commerce in Washington. The Council also received two preliminary reports that would be considered by the State Board of Education on March 12.

The Council noted that the Michigan Delegation to the American Medical Association, at a caucus on February 20, had elected D. N. Sweeny, Jr., M.D., as Chairman, Otto K. Engelke, M.D., as Vice-Chairman, and J. C. Danforth, Jr., M.D., as Treasurer. Retiring Chairman Luther R. Leader was thanked for his service to the Delegation.

The Council approved a recommendation by the Chairman that Otto K. Engelke, M.D., continue as MSMS representative to the Data Process Clearing House Information Center.

The Council was informed that the Michigan Hospital Association had appointed MSMS Legal Counsel Kerr to serve on a MHA committee to develop a consent manual.

COUNCIL CHAIRMAN TAYLOR discussed a letter sent to Michigan Medical Service Chairman Wellman regarding Blue Shield letters being sent to patients and physicians. This letter was authorized by The Council at its last meeting and had been distributed in advance to members of The Council. Upon recommendation, The Council adopted a recommended procedure in situations where Michigan Medical Service and other insurance companies are questioning a physician's charges. "First, contact the doctor and review the problem with him; if this does not resolve the situation, then second, refer the problem to the local county medical society, and finally, if necessary, refer the problem to the regional advisory committee of Blue Shield which was established as an appeal mechanism in Resolution 29 of the September, 1968 House of Delegates." The Council further recommended that this procedure be suggested for use by all physicians, component medical societies and Blue Shield in these situations.

President McCabe and Vice-President Louis Hayes, M.D., Michigan Medical Service, presented a report which included a discussion of enrollment, participation, reasonable charge performance review, current charge patterns and over-the-screen charges. The report contained information that the Blue Shield Board at its next meeting would consider a recommendation of the executive committee that individual case participation be revoked. Council acted to communicate with each member of MMS Board of Directors reminding them that "Revocation of individual case participation would reverse the decision of the Board under the consent judgement, conflict directly with the policy of the medical profession, and adversely affect Blue Shield and its subscribers."

The Council authorized President Lightbody as the official MSMS delegate to the dedication of the new Towsley Center for Continuing Education at the University of Michigan, to be held on March 27.

Legal counsel reported that consultants to study the professional liabilities insurance recommendations of the MSMS Insurance Committee had been appointed and that their reports would be submitted on or by April 10, 1969.

Correspondence from Michigan State University Institute of Biology and Medicine re MSMS support of medical and/or health students was referred to the Finance Committee for consideration.

THE COUNCIL WELCOMED E. G. Yudashkin, M.D., representing Director William H. Anderson, M.D., of the Michigan Department of Mental Health. Dr. Yudashkin discussed mutual problems and plans of the Department.

In response to a request from the Michigan League of Nursing for a speaker, The Council offered to provide a speaker of choice.

The Council approved a letter from Chairman Taylor to the Michigan Department of Health suggesting that MSMS might tentatively approve the Health Department's project on Delineation and Scope of Services in Hospitals for Title XIX patients, with certain stipulations.

Upon request, MSMS was asked to endorse a "library service program" for financing through Michigan Regional Medical Program. Upon recommendation of the County Societies Committee, The Council did approve this library grant through MARMP.

The Council considered the reports of the following committees: Awards, Medicine and Religion, Hospital Relations, Highway Injury, Rehabilitation, Emergency and Disaster Medical Service, Legal Affairs, Maternal Health, Mental Health, Medical Aspects of Organized Athletics, Special Report of Joint Meeting of Committee of Postgraduate Medical Education with the MARMP Task Force on Continuing Medical Education.

Michigan Mediscene

April 30-May 1 – MSMS Woman's Auxiliary, Spring Conference, Shanty Creek Lodge, Bellaire

May 1 – Conference for Medical and Education Reporters and Yates Lecture, MSU Kellogg Center

May 6 – Lansing Junior League, MSMS Headquarters, East Lansing, 1:00 p.m.

May 7-9 – Michigan Public Health Association Annual Meeting, Pick-Durant Hotel, Flint

May 8 – MSMS ANNUAL MEDICINE AND RELIGION WORKSHOP, MSMS Headquarters, East Lansing, 10:00 a.m.

May 8 – MSMS ANNUAL CONFERENCE ON MEDICAL ASPECTS OF HIGH SCHOOL ATHLETICS, Kellogg Center, Michigan State University, East Lansing

May 10 – Michigan Society of Pathologists, Mt. Sinai Hospital, Detroit, 1:30 p.m.

May 12 – American College of Emergency Physicians, MSMS Headquarters, East Lansing, 5:00 p.m.

May 14-16 – 1969 Medical Staff-Trustee-Administrator Forum sponsored by the Michigan Hospital Association at Boyne Mountain Lodge

May 17 – 14th Annual All-Day Scientific Session of The Michigan Society of Anesthesiologists, Sheraton-Cadillac Hotel, Detroit

May 21 – Annual Muscle Symposium, Wayne County Medical Society Auditorium, Detroit

May 22 – Wayne State University Alumni Clinic Day, Sheraton-Cadillac Hotel, Detroit

May 22-23 – Gull Lake Meeting of the Committee on Maternal Health, Kellogg Biological Station, Gull Lake

May 25-27 – Drug Information Association Annual National Meeting, Sheraton Cadillac Hotel, Detroit.

May 26 – American College of Emergency Physicians, MSMS Headquarters, East Lansing, 5:00 p.m.

June 4 – MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

June 19-21 – Upper Peninsula Medical Society 74th Annual Meeting, Indianhead Mountain Ski Resort, Bessemer.

June 27-28 – Annual Summer Meeting of the Michigan Orthopedic Society, Hidden Valley, Gaylord. Inquiries to be sent to G. D. Stilwill, M.D., Secretary, 2909 E. Grand River Ave., Lansing 48912

July 13-17 – American Medical Association Annual Meeting, New York City

July 26-27 – Michigan State Medical Assistants Society Summer Seminar, Mackinac Island, Grand Hotel

July 31-Aug. 2 – Midsummer Meetings of Medical and Health Organizations of Michigan, Boyne Mountain Lodge, Boyne Falls

July 31-Aug. 2 – MSMS MIDSUMMER SESSION OF THE COUNCIL, Boyne Mountain Lodge, Boyne Falls

Sept. 28-Oct. 3 – MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION, Sheraton-Cadillac Hotel, Detroit

Sept. 30-Oct. 2 – Annual Convention of Woman's Auxiliary to Michigan State Medical Society, Hotel Pontchartrain, Detroit.

Oct. 1 – MSMS COUNCIL, Sheraton-Cadillac Hotel, Detroit

Oct. 9-11 – 12th National Conference on Physicians and Schools, Pick-Congress Hotel, Chicago

MICHIGAN MEDICINE ON MICROFILM

Microfilmed copies of current as well as all back issues of *Michigan Medicine* are available through University Microfilm Services, a subsidiary of Xerox Corporation. The 35 mm film fits all standard viewers and provides the JOURNAL in miniature at a savings on binding and storage costs. Write for information or send orders direct to University Microfilm Services, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

WHY BELONG?

The following passage is excerpted from an editorial which appeared in the *Oakland County Medical Society Journal*. The author is a Birmingham physician.

"The medical society is not run by an establishment; it is run by default. The same individuals run the organization every year because they are the only ones willing to do the necessary work. The individual member may not agree with the viewpoints and policies of these men but no one will know until the individual comes to meetings and starts participating. Communication is perhaps the essence of the society. This has to be more formal than our preferred system of hearsay in the coffee shop and doctor's lounge.

"Writing to the editor is not all that hard, especially with present dictation systems; however, it happens seldom. Our representatives to other organizations, such as Blue Shield, need very much to know what our local society's needs and wants are but they seldom find out because few take the time to communicate.

"Why should we bother to belong? It is simple. Medicine, although practiced by diverse individualists, has essentially only one organization to represent it. That organization starts at the county society level. Any medical individual who wants any say in that organization has to belong to it. In another aspect, any governmental body that is to deal with medicine will want to deal with its organized group, starting or finishing at the local society level.

"We must not only belong to our local medical society, we need to participate in it."

ROBERT J. SCHOENFELD, M.D.

Patient comfort is your concern.

Patient comfort in chronic constipation is enhanced by restoration of normal pattern of evacuation.

- ☐ Gentle neuroperistaltic stimulation is mediated through the Auerbach's plexus in the colon
- ☐ Aids in rehabilitation of the constipated patient by facilitating regular elimination
- ☐ No laxative tolerance or rebound constipation reported in clinical experience
- ☐ Even many previously intractable cases have been successfully treated with SENOKOT preparations
- ☐ Virtually free of side effects at proper, individualized dosage levels
- ☐ Dosage may be gradually reduced and eventually discontinued in many cases, upon restoration of normal pattern of elimination

Dosage: (preferably at bedtime)—*Adults:* 2 tablets (max. 4 tablets b.i.d.). *Children:* (over 60 lb.) 1 tablet (max. 2 tablets b.i.d.). **Supplied:** Bottles of 50 and 100 tablets.



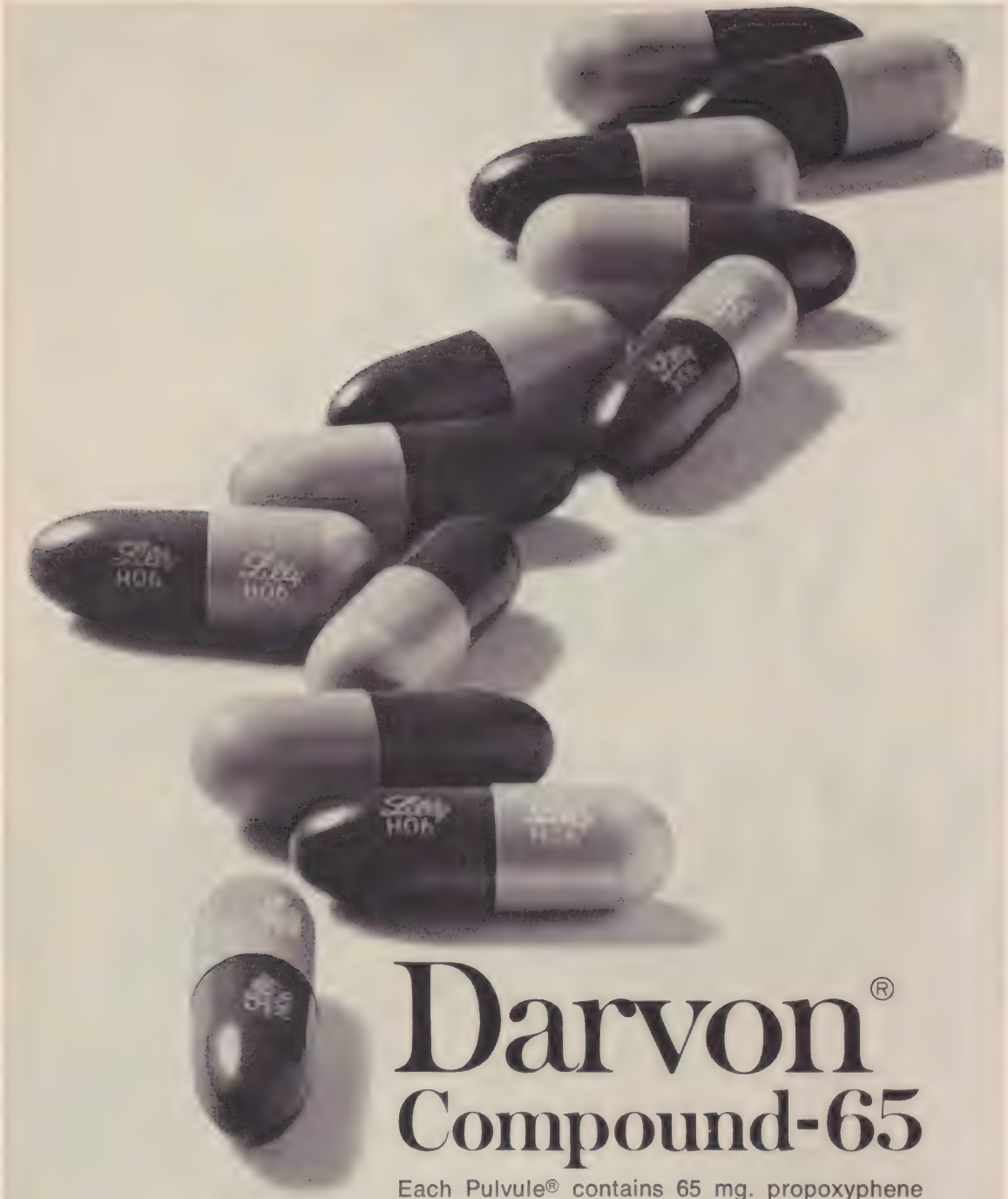
Purdue Frederick

The Purdue Frederick Company, Yonkers, New York 10701

Senokot Tablets

(standardized senna concentrate)

© COPYRIGHT 1969, THE PURDUE FREDERICK COMPANY 36869



Darvon®
Compound-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Lilly

Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.

900252

Massive Successes, Massive Problems
Key Governor's View of Today's Medicine

BY WILLIAM G. MILLIKEN
GOVERNOR, STATE OF MICHIGAN



There are amazing accomplishments daily in medicine in Michigan and it would be relatively easy to make it seem as though all is well by noting progress in terms of personnel, medical achievements or dollars.

However, just as the successes are massive, so too the problems are massive and we could outline a grim picture of health shortages for many of our people. It is clear that health is still, to a large extent, a purchaseable commodity, most often available for the well-to-do, and that many others are sick simply because they cannot afford the care they need.

While both views can be well documented, I basically am optimistic concerning the future.

Although our problems are immense, continued medical accomplishments indicate that progress will continue. However, this will be true only if we strenuously apply ourselves to the problems that face us today.

BROAD CONSIDERATION of health problems must include the environment of our people, environment which affects their daily lives on the job and off. This is one of the primary focus points in my recent recommendations concerning application of the recreation and clean water bond issues.

Through programs such as these we can make a direct, beneficial impact on the problems of health of the entire person. The air we breathe and the ways in which we are able to make use of recreational opportunities can have a profound effect on the physical condition of our bodies.

For this reason, proper allocation of these bond monies is vital to health. Such allocation is one of the many ways in which government can respond to needs.

There have, of course, been a remarkable number of statutes dealing with health at the state level.

SINCE 1965, more than 50 health laws have been passed dealing with PKU testing, migrant camp licensing, community health centers, air pollution control, solid waste disposal control, measles immunization, kidney disease dialysis training and laboratory and hospital licensing.

One major, current concern of mine involves medical education. It seems that immediate action is necessary to deal with the growing shortages of physicians and other health care personnel in Michigan. Certainly one major step must include maximum expansion of present medical education facilities in our state if the crucial problems of skilled personnel are to be met.

We are also aware that there needs to be greater coordination in health care services because there is now some splintering of services which prevents the best application of treatment. However, through the efforts of our Comprehensive Health Planning Commission and the cooperative efforts of our state departments, this fragmentation will be minimized.

This we must do. There is no other choice.

ALL PEOPLE, whether they be physicians, teachers, factory workers or governors, in this complex, inter-dependent world of today, must be concerned about such matters as education, housing, jobs and health upon which they can have some influence.

One national newspaper recently found that some drugs may cost three times as much in Detroit's inner city as in the suburbs. Such findings as these cry out for action by us all.

It is not enough for a person to say he isn't running the store or isn't in the drug business. While our complicated world may seem to permit us all a place to hide from responsibility for injustices, none of us can actually escape for long.



AUTHOR
GOVERNOR MILLIKEN

Public's Right to Good Health Concern of State Department

BY R. G. RICE, M.D., DIRECTOR
MICHIGAN DEPARTMENT OF PUBLIC HEALTH

A major and probably irreversible change is taking place in public health in Michigan and the nation. The primary impetus toward this change is the growing conviction on the part of the people that the opportunity for health, like education, is a basic social right. Out of this conviction have emerged two basic concerns or demands: the right to a healthful environment; and the right to high quality, readily accessible, health care.

People believe they have a right to breathe air, use water, and live on land which neither insults the senses nor sickens the body. They believe they have a right to the best possible medical care readily available in the best equipped facilities.

In response to these convictions, recent years have seen unparalleled interest and activity in programs which affect health. Each year, more and greater responsibilities are given to public health agencies by legislative action, both state and Federal.

THE IMPACT of such Federal legislation as Medicare and Medicaid by themselves, not to mention Comprehensive Health Planning and Regional Medical Programs, would have represented a major revolution in public health programming. But state health legislation also continues to increase.

Last year alone, the Michigan Department of Public Health was given responsibility for licensing all hospitals, all clinical laboratories, all ambulance services, and all food service establishments, and for providing training in home hemodialysis for kidney disease. In addition, the department will play a major role in carrying out the provisions of the recent bond issue for clean water through supervision of expanded and improved waste-water treatment plants in the state.

Other new programs mandated in the past several years include air pollution control, solid waste disposal control, PKU testing, family planning services, migrant camp licensing and well driller licensing, measles immunization, tuberculosis testing for entering school children, and registration of nursing homes of less than four beds.

Even a cursory review of such legislation reveals that public health is moving toward greater involvement in (1) helping to assure a healthier environment by establishing more stringent controls over all sources of pollution; and (2) helping to establish an effective and equitable system for the delivery of health care to all segments of our population.



There are those who decry governmental encroachment on industrial and other sources of pollution, just as there are those who assail governmental intervention into any phase of medical care. These people ignore, or overlook, the fact that such governmental action takes place only in response to public demand, and because it appears at least to be the most effective way of solving a problem.

THE DEGRADATION of our environment has reached the point where without some form of collective action, no effective control over individual sources of pollution can be attained. And so, today, we have governmental agencies establishing and enforcing standards for water quality, air quality and land use.

In terms of medical care, the situation is somewhat analogous but basically different. The objectives of the providers of care and of the public health agency run a parallel course and are complementary. The providers of care – the physicians, nurses, physical therapists, etc. – deal with the individual directly in terms of prevention, treatment, and rehabilitation. The public health agency deals with groups, and attempts to help assure a total system within which individuals, particularly the minority poor, can be provided essential health services and protection.

The primary example of expanded governmental responsibility for health care relates to Medicare and to Medicaid. Medicare is, of course,



AUTHOR
DOCTOR RICE

basically a health insurance program at the Federal level, but the state health agency is responsible for certifying facilities for eligibility for reimbursement.

WITH MEDICAID, the state's role is greater and involves a number of ancillary activities. The state health agency is involved in such things as certifying hospitals and nursing homes to the Department of Social Services, recommending reimbursement rates to Social Services, etc. The state's primary concern is in opening avenues by means of which individuals may obtain the necessary care which is provided by the private practitioners.

There are, however, some groups in some areas who are unable to get appropriate medical care because of manpower shortages, or for other reasons. Under these circumstances, such programs as the Detroit Maternity and Infant Care Project and the Lake County Area Comprehensive Health Care Project came into existence.

Collectively, it became clear that mothers and infants in the inner city of Detroit suffered from a far greater mortality and morbidity rate than was acceptable, and that the impoverished residents of the Lake County area suffered from a serious lack of medical care and medical care facilities. One method of attempting to cope with these problems was by direct governmental intervention. It might not be the best, or the only, method but as yet, no better alternative has been suggested.

As with any public health program, the success of these and other activities related to medical care will depend upon cooperative effort, mutual trust, and sympathetic understanding on the part of all concerned. This in turn requires the continuance of open channels of communication by means of which useful and meaningful discussions of programs and problems can be maintained.

The ultimate goal is to achieve a society in which no person unnecessarily becomes sick or dies prematurely. While that goal may not be wholly obtainable, it is one upon which all of us can agree, and toward which we can all humbly commit ourselves.

State Department of Mental Health Has Many Plans for Coming Year

BY WILLIAM H. ANDERSON, M.D., DIRECTOR
MICHIGAN DEPARTMENT OF MENTAL HEALTH

Improved institutional services, expanded community services, modernized statutes, accelerated construction schedules, systematized data collection, and reorganized administration are all top priority items in the Department of Mental Health's plans for the coming year.

Action on all these fronts is necessary now if we are to meet our obligations to the citizens of Michigan in providing modern, effective programs for the mentally ill and mentally retarded.

All ages, all conditions of mental illness and retardation, and the full range of physical handicaps are represented in our daily census of 26,000 inpatients — approximately half of whom are being treated in nine state hospitals for mentally ill and half in nine state institutions for the mentally retarded. Community mental health programs, funded at 75% matching through the Department, are now operating in counties containing 91% of the state's population.

OUR HEALTH SERVICES include not only treatment of mental problems, but the care of nursery, bedridden and senile patients. We operate schools for emotionally disturbed children and for the educable retarded; conduct rehabilitative and training programs; and provide a wide variety of outpatient services.



During the last few years, rapid changes in the field of public psychiatry have been reflected in alterations of state and local mental health programs.

Community mental health legislation in Michigan served as a stimulus for the development of new programs throughout the state. With the assistance of state and federal funds, communities are developing more outpatient and short-term inpatient services. Ultimate goal of these programs is to afford every citizen an opportunity to receive quality psychiatric care in or near his place of residence.

The Department of Mental Health is fostering growth of community services with attention to the efficiency and comprehensiveness of the programs, while concurrently striving to improve the

level of treatment and care for the state institution patients who are its direct responsibility.

Inherent in the state-wide administration of these mental health activities is the demand for continuing efforts to up-grade the quality of services, to operate more efficiently, to adequately maintain facilities, and to replace old, out-moded, and out-worn buildings.

AS INPATIENT LOADS have been reduced in hospitals for the mentally ill, staffing ratios have improved. However, they are still well below standards established by the American Psychiatric Association. Institutions for retarded fall short of standards recognized by the American Association on Mental Deficiency. We are continuing to request sufficient funds to improve staffing ratios, and, as a guide, are developing staffing standards which will set base-goals for manning specific areas of patient service.

Program definitions have been established at institutions for retarded so that uniform performance measures may be applied. Refinement of program definitions at hospitals for mentally ill are underway. Manning tables are being prepared for each program so that use of personnel may be traced and compared — eventually making it possible to establish staffing patterns on a program basis.

A project has been started for the development of self-instructional techniques for in-service training in hospitals for the mentally ill.

Many of the state facilities for the mentally retarded are inadequate in quality, functional design and bed space. The waiting list remains relatively high; there is over-crowding in certain institutions; and the temporary facility at Ft. Custer must be replaced.

The Department has recommended construction of new 250-bed and 500-bed facilities in several metropolitan areas. The governor and the legislature are giving us their support in a five-year plan which will help considerably to meet the demands. We are also developing plans for scheduled construction projects to replace obsolete buildings at established institutions.

THE DEPARTMENT IS not requesting construction of added capacity for mentally ill patients except for children's services. Scheduled remodeling of existing structures and replacement of obsolete buildings will be carried forward as funds are available.

To bring the building needs into focus, the Department is initiating a survey of all facilities. This survey will help us determine the structural and functional adequacy of the present physical plants and will serve as a guide to long-range capital outlay plans.

In addition to the facilities survey the Department has requested funds to:

- develop a management information system which will give quicker and more accurate data on trends and costs, and will facilitate comparisons of methods as well as more efficient use of available resources;
- review and revise the mental health statutes in order to bring commitment laws into conformity with current concepts of hospitalization, to provide better coordination between state and local programs, to develop a financial structure which supports program objectives, and to clarify responsibilities and authorities.

RULES AND REGULATIONS of the Department are in the process of continuous revision to keep them relevant to current needs and changing trends. This is particularly important as the law pertaining to the community mental health services (P.A. 54, 1963) is more fully implemented and responsibilities of the Department under the Act are clarified.

New manuals have been published covering the standards of operation for licensed residential facilities, licensed mental hospitals and psychiatric units of general hospitals, and community day training centers for the severely retarded.

The community placement manual is under revision and will soon be republished.

Uniform requirements have been established for fire and safety programs in our institutions, and arrangements are now being made to have follow-up visits by central office staff to assure compliance.

Requests have been sent to the State Fire Marshall, Director of Agriculture, and Director of the Department of Public Health to conduct annual inspections of our institutions in order to achieve and maintain higher standards of safety, food handling and sanitation.

With the cooperation of the Michigan Pharmaceutical Association, a survey of drug management in our institutions has been conducted and a pharmacist has been engaged on a temporary basis to assist in the development of a model system.



AUTHOR
DOCTOR ANDERSON

Michigan Health Council Adds Program Specialists To Staff

BY JOHN A. DOHERTY
EXECUTIVE DIRECTOR
MICHIGAN HEALTH COUNCIL

A Michigan Week report from the Michigan Health Council affords the opportunity to report a major step in the Council's progress.

The rapidly growing need for medical, dental, veterinarian, paramedical and all associated health personnel has led the Michigan Health Council to increase its staff by adding two program specialists. These men, experienced in organizing and recruiting, are building what should prove to be effective programs to motivate young people toward seeking health careers.

Together this team has the know-how to build and implement what will begin as a two part attack on the health manpower shortage. The two distinct, yet complimentary programs will "zero in" on youngsters in school and in their free time. Through youth programs such as health clubs, science clubs, 4-H, F.F.A., and Boy Scout Explorers, the young people can be reached in an informal atmosphere outside of school.

TO REACH the youngsters in school, guidance counselors will be informed and themselves counseled about health career opportunities available to their students. A comprehensive, up to date, easy to use "Guidance Counselors' Handbook for Health Careers" is being compiled. This will be a large loose-leaf book to allow up-dating on a continuing basis. To introduce this workbook to counselors throughout Michigan, area meetings will be arranged to train the counselors in the use of the book. Each of the more than 200 health careers will eventually be covered in detail in the book. It will tell such details as preparation needed, where to train, and scholarships available.

Implementing the counselors' task, a series of sharp, up-to-the-minute posters designed for the "Now Generation" will be available for school bulletin boards. These will direct the students to the counselor or to the Health Council for information about health careers.

We predict the Counselors' Guide, supported by our programs, will be one of the most read and utilized volumes in the counselors' library. It is a sorely needed reference piece.

The second phase of the recruiting program will begin with the Explorer part of the Boy Scout program. Aimed at young adults, this can be a specialty oriented program in which the members may pursue study and evaluation of careers and professions.



One of the very early Explorer Posts specialized in medical careers exploration. Sponsored, and closely supported by one of the large pharmaceutical houses in New Jersey, this Explorer Post proved that the then "new" Explorer specialization program would prove popular with young men. Detroit's St. John Hospital has a strong and busy medical careers Explorer Post operating under its sponsorship and guidance.

One aim of the health manpower program will be the organization of health careers Explorer Posts wherever sponsorship and leadership can be found. Simultaneously, other youth program groups would be urged and assisted in including health careers in their own activities.

In support of the two major initial recruiting thrusts, films, filmstrips, brochures and program helps are available from the Health Council, from professional associations, and from health agencies. TV and radio spots are available to broadcasters. The total public information effort will be in the "Now Generation" style that commands the attention of the young adult.

Other programs planned by the Michigan Health Council include the annual Michigan Health Congress on Health Manpower scheduled May 21 at Towsley Center for Continuing Medical Education at The University of Michigan.

THE MICHIGAN Health Council's Health Careers Mobile has begun its annual tour 'round



AUTHOR
MR. DOHERTY

the state. The first stop was Wayne State University where hundreds of Detroit high school students toured the exhibit-filled vehicle. Almost completely refurbished, with many new exhibits and a number of new signs on the exterior, the Health Careers Mobile will cover much of the state before returning to Lansing in the Fall.

John P. Hyde, until recently vocational counselor and co-op coordinator at Northville High

See Related Art in Yellow Photo Pages

School is heading the program designed to inform counselors about the health career opportunities available to their students. Armed with a bachelor's degree in agricultural education from Michigan State University, a master's degree in teacher education from M.S.U., and with further graduate work in counseling and administration at University of Michigan, Mr. Hyde knows the needs of the counselor.

The other member of the new manpower team, William F. Bresler, has had a long career in organization work with the Boy Scouts in New Jersey and New York. He has a bachelor's from Pace College, New York City. He was closely involved with the "new" Explorer program when it was in its infancy.

Working under the direction of Michigan Health Council director Tony Doherty, Messrs. Hyde and Bresler will travel through much of Michigan in their quest for health career candidates. With over 200 health occupations to offer, their efforts can hardly fail to reach thousands of young ladies and men. Armed with information about quality careers and how to pursue them, the men are available to talk with science clubs, career clubs, Explorer Posts, 4-H, F.F.A., Y.M. and Y.W. and anyone else who will listen to their story.

The Michigan Health Council may be reached at Box 431, East Lansing, 48823 or by phone: 517 337-1615.

MICHIGAN STATE MEDICAL SOCIETY
FUTURE ANNUAL SESSION DATES

1969 - Detroit, September 28-October 3
1970 - Detroit, September 20-25
1971 - Grand Rapids, October 3-8



Michigan State Medical Society
The professional association of Michigan doctors of medicine
120 West Saginaw
East Lansing, Michigan 48823

University of Michigan Health Team Geared for Extensive Expansion

BY WILLIAM N. HUBBARD, JR., M.D.
DEAN, SCHOOL OF MEDICINE
THE UNIVERSITY OF MICHIGAN

MICHIGAN MEDICINE
SALUTING MICHIGAN WEEK

During 119 years of continuous operation the Medical School of The University of Michigan has graduated 11,368 doctors of medicine. It will add another 200 to this total in June of 1969. From a graduating class of 6 in 1861, output has risen to 200 for the current year largely in response to the State's need for more and more practicing physicians. The end is not in sight for The U of M, where planning is underway for a further 50 percent expansion of incoming classes to 300.

The clinical resources for teaching these students, limited for years to patients in the University Hospital, have been increased through affiliation with three core hospitals – St. Joseph Mercy and the Veterans Administration Hospitals in Ann Arbor and the Wayne County General Hospital in Eloise. The addition of 500 beds to the present 931 capacity of the University Hospital is under study. The new 200-bed C. S. Mott Children's Hospital will soon be in operation providing long-needed facilities for the diagnosis and treatment of childhood diseases.

THE INCREASE to classes of 225 and then to 300 can be contemplated when the recently announced affiliation with the Henry Ford Hospital in Detroit becomes operative. The Henry Ford Hospital complex with its firmly established program of graduate clinical teaching and its excellent Edsel B. Ford Institute for Medical Research are ideally suited to operate in concert with The University of Michigan in overall medical education.

New impetus to postgraduate medical instruction at the U of M has been provided by the completion of the Towsley Center for Continuing Medical Education. The beautiful and highly functional Towsley Building is an appropriate adjunct to the forward-looking plans of the Department of Postgraduate Medicine, built upon a firm foundation of performance since 1927.

The Upjohn Center for Clinical Pharmacology, a gift of the Upjohn Company of Kalamazoo, is currently under construction in direct connection with the Kresge Research Complex and the University Hospital.

The second unit of the Medical Science Building will be occupied in July of 1969 bringing all of the teaching and research activities of the Medical School on the Ann Arbor campus within the perimeter of the Medical Center.

PARALLEL TO growth of the Medical School in space and faculty numbers, the 100-year old "University Hospital," the first university-owned hospital in the country, has itself become a "medical center." Beginning as far back as 1907, clinical training beyond graduation has been offered to steadily increasing numbers of physicians. Today the University Hospital is approved for 41 internship and 369 residency positions annually. Here also a great variety of health services are offered to patients through the cooperative efforts of faculty physicians and dentists, residents in many specialties, interns, nurses, nurses' aides, technologists of many types, social workers, occupational therapists, and the clergy, as well as many other members of the staff.

After searching study a new organizational plan for the Medical Center has been designed and soon will go into effect. The new organization is intended to consolidate the activities and the interests of the several schools within the University which cooperate in teaching and the provision of comprehensive and sophisticated medical care. This includes, of course, the hospital itself and its outpatient facilities.

TO KEEP PACE with the headlong production of new basic knowledge of significance in the provision of health care, the pattern of teaching in all of the health sciences is undergoing profound changes designed to narrow the gap between the products of research and their useful clinical application. Transition from traditional teaching methods to those presently emerging is a complicated and difficult procedure, which is progress-



AUTHOR
DEAN HUBBARD

ing as smoothly as one could hope. Students are being introduced in their first year to clinical problems presented by a vertical core type of teaching which integrates the contributions by all Medical School disciplines involved.

Steps are being taken to emphasize the importance of comprehensive family health care in the training of physicians and nurses through a new Community Medicine Program. Coincidentally the particular problems and needs of underprivileged, urban populations will be specifically served.

A centenarian hospital and a medical school approaching the age of 120 years might be expected to have become somewhat static in operation and growth. Clearly this is not true of The University of Michigan's health team.

WSU School of Medicine Growing in Many Directions

BY ERNEST GARDNER, M.D.
DEAN, SCHOOL OF MEDICINE
WAYNE STATE UNIVERSITY



A key component of the Detroit Medical Center, the Wayne State University School of Medicine measures its growth and its progress in a number of ways.

Most visible, of course, is the construction of new buildings underway on WSU's new medical campus in the Medical Center. Begun last year and destined to cost just under $25 million when completed, the Basic Science Instructional Facility will enable the medical school to increase enrollment in the entering class from 130 to 256 students. Target year for the expanded student enrollment is 1971. Preparations for this expansion, begun several years ago, include increasing the faculty strength in our 24 departments and concentration on new methods of learning for our students.

Groundbreaking for the Shiffman Medical Library was an important event of last winter. A vital link in the educational process, the library facility is designed to hold 160,000 volumes, will contain 48 teaching carrels equipped with self-instruction units, and study space for 800 persons.

THE NATION'S FIFTH Regional Medical Library, with administrative offices located at WSU, was announced early this year by the National Library of Medicine. The new regional library serves the health professions in Michigan, Ohio and Kentucky. Other participating institutions are the University of Detroit, Michigan State University, University of Michigan, Cleveland Health Sciences Library, Ohio State University, Medical College of Ohio at Toledo, University of Cincinnati, University of Kentucky, and University of Louisville.

Purpose of the library is to improve the flow of biomedical information through local medical libraries to medical practitioners, researchers and educators throughout the three state region. Representatives of all participating institutions serve on the executive committee.

A NEW HOME for the Department of Pediatrics will be a reality when the new building for Children's Hospital of Michigan is completed early next year. Construction of a three-story addition will begin this spring at the Rehabilitation Institute, location of the WSU Department of Physical Medicine and two allied health science divisions, Occupational Therapy and Physical Therapy.

Other Medical Center hospitals affiliated with the School of Medicine — Grace, Harper and Hutzel — are involved in major renovations or are planning future expansion. These institutions contain WSU teaching beds for medicine, neurology, neurosurgery and gynecology and obstetrics.

Installation of Michigan's first scanning electron microscope for biomedical research was completed in mid-January of this year in the Theodore and



AUTHOR
DEAN GARDNER

Mina Bargman Foundation Laboratory for Cell and Molecular Research. The laboratory is located in the WSU Medical Research Building, first new structure to go up in the Detroit Medical Center.

The working laboratory contains a total of four electron microscopes and ancillary equipment, including complete photograph facilities. The $75,000 scanning microscope provides three-dimensional views of surfaces of cells and cellular inclusions. Images can be directly observed, photographed, televised or stored on tape for future evaluations.

Since 1945, when the class entering numbered 65, the School of Medicine has doubled in size, an expansion greater than any other medical school in the country. Throughout its history, the School of Medicine has been situated in the heart of downtown Detroit, and it has remained close to its place of origin for 100 years. It is the only medical school in Detroit, a metropolitan area including a population of more than four million.

SINCE ITS INCEPTION, the School of Medicine, first with Harper Hospital and then with Detroit Receiving Hospital (now Detroit General) has been the principal institution providing medical and surgical care for the sick poor of Detroit, especially in the Inner City. Currently nearly half a million sick and injured are cared for each year by the school's faculty, interns, and residents.

The master planning by the School of Medicine has been developed over four 10-year projections and has focused on fiscal analysis, capital programs, organization, relationship of the medical school to the City of Detroit and the State of Michigan, and, of no little importance, the curriculum.

A Curriculum Study Committee, first appointed in 1963, was directed to study the curriculum of the School of Medicine and to make recommendations with a view to meeting the rapidly evolving needs of medical education in a highly sophisticated, fast-moving technological society.

A GREAT DEAL of discussion and committee effort has produced fairly general agreement to: reduce the formal courses required of all students to a core in both the basic and clinical sciences; teach the core courses by an interdisciplinary approach insofar as possible; schedule use of free time by students for special or advanced work during the first two years; make the fourth year a structured elective for either broad or in-depth studies, depending upon the students' interests and abilities; introduce patient care into the basic science course through correlative clinical and collaborative teaching; introduce basic science components into the clinical sciences; introduce advance placement, and begin intensive review of the examination procedure and its educational role.

Changes in the curriculum, following these guidelines, were begun last summer. Work is continuing on modifications and revisions so that tomorrow's physicians will be better equipped to handle problems and techniques of the future, with full understanding of the impact of culture, environment, and economic conditions upon health and disease.

New MSU College of Human Medicine "More Than Ready to Move Ahead"

BY ANDREW D. HUNT, JR., M.D.
DEAN, COLLEGE OF HUMAN MEDICINE
MICHIGAN STATE UNIVERSITY



The Michigan State University College of Human Medicine is approaching a decisive time in its brief but busy history. Over the past three years, we have admitted three classes of 26 medical students each. This fall we plan to admit 30 students by making maximum use of all our existing facilities and faculty and without any special increase in funds, simply because we feel that it is vitally important for a medical school today to admit every student it can effectively accommodate.

Thanks to funding by the state and federal governments and the Kellogg Foundation for our new Life Sciences Building, we expect to be able to expand our entering classes to 64 students in 1971 when construction is completed. This building will also allow the University to graduate nearly 100 nurses annually – about double the present

number — and to expand its graduate and post-doctoral programs in pharmacology.

The first class, which entered in 1966, is now completing its course of study by taking clerkships in hospitals in Lansing, Grand Rapids, and Flint, and is preparing to transfer to other medical schools this fall. Some of the students in this class will be transferring at the senior level, some at the junior level, depending on the individual's level of achievement and the policies of the school that he has chosen to attend.

WE BELIEVE that it is unfortunate that these students must transfer to other schools to complete their medical education, especially since many of them are going out of state. Also, it will be necessary for the class that entered in 1967 to transfer next year. However, if the state sees fit to fund a full medical program, the students which entered in 1968 will be able to complete their medical degrees at MSU.

Governor Milliken has recommended in his budget that we receive $200,000 to plan expansion to a degree-granting program. While this represents only a very modest beginning, passage of this appropriation will be an indication that the legislature and the governor are willing to move ahead with the necessary funding in subsequent years.

We are more than ready to move ahead. We have a strong, imaginative faculty and intelligent, conscientious students. The curriculum is highly innovative, and, we believe, in the vanguard of medical education nationally. Instead of an episodic, piecemeal approach to curriculum planning we are trying to determine what skills, knowledge and attitudes a doctor will need in future years, and to develop analytically and systematically a total curriculum that will meet the prospective doctor's needs.

OUR CURRICULUM planning has been made particularly difficult because we are trying to break the traditional mold of education and at the same time to prepare the students to transfer to traditional schools. As a result, we have not been able to be as innovative and as flexible as we would have liked to be. Nevertheless, several new features have proved successful. We have started a two-year core sequence in human biology and behavior in which students study growth and development of the human being and his reaction to disease and other stresses from conception to senescence. Throughout the curriculum we have emphasized the importance of the person. The student's first contact with patients, which comes early in his studies, emphasizes learning to know the patient and to acquire interviewing skills.

Realizing the urgent need for community practitioners, we have emphasized learning in community contexts. Our affiliations with hospitals and other health agencies in Lansing and other areas will enable our students to see how their chosen profession is practiced in community settings. Through a recent bequest awarded by the American Medical Association, our Office of Medical Education Research and Development is developing a program that will enable community doctors to acquire teaching skills.

Although we are only a small college in numbers of students and clinical faculty, we have more university resources to draw on than most well-established four-year schools in the country. Even more importantly, we have the physical proximity and administrative flexibility that allows us to draw on university-wide resources readily.

The medical faculty is anxious to develop its innovative curriculum more fully. Plans have already been proposed for a full program which are even less traditional than those we have already developed. One of the principle characteristics of the new curriculum is a flexibility that will allow students to proceed at their individual rate rather than in lock-step progression. This will enable the more brilliant, more ambitious, more energetic students to complete the medical curriculum in a very short period of time. It will also allow the less well-prepared students, particularly those handicapped by disadvantaged backgrounds, to develop slowly but fully.

ANOTHER IMPORTANT concern of the College of Human Medicine is improving health care. Without de-emphasizing our present strong research programs in the biological areas, we are planning a major program in health-care research.

In order to develop fully in teaching, research and service, we will need additional facilities as well as increases in budget. Specifically, we will need a second Life Sciences Building for our clinical faculty and a teaching hospital-outpatient health center. The health center will be relatively small — perhaps 300 beds — because we expect to use community facilities extensively. During the initial phase of the full program, when only a small number of students are involved, we expect to use community facilities exclusively.



AUTHOR
DEAN HUNT

Comprehensive Health Planning Accelerating in Michigan

BY ANDREW D. HUNT, JR., M.D., CHAIRMAN
COMPREHENSIVE STATE HEALTH PLANNING
COMMISSION AND ADVISORY COUNCIL



Implementation of Michigan's comprehensive health planning effort began to accelerate this year with organization of 3 areawide planning agencies and the appointment of a 32-member Advisory Council in October to assist the 7 member State Commission. The Council will be energizing force at the state level in carrying out the mandate of P.L. 89-749, the Comprehensive Health Planning and Services Act of 1966:

> "The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health obtainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that federal financial assistance must be directed to support the marshalling of all health resources — national, state, and local to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts."

Thus, the structure to carry out comprehensive health planning in Michigan is now falling into place, with a State Commission responsible for program decisions, an Advisory Council of citizens and professionals to represent the public interest and, ultimately 11 areawide comprehensive health planning agencies.

THE INTENT of the law is far-reaching, idealistic, and therefore unspecific as to its ultimate goals, and flexible as to its procedural methods. These very complexities, uncertainties and idealistic concepts insure the element of adaptability so important in today's rapidly changing health scene. Comprehensive health planning, then, offers an exciting opportunity for consumers and professionals alike, with the strong probability of providing a vitally important service to the welfare of the people of Michigan.

Implementation of comprehensive health planning in Michigan has generated confusion and anxieties among groups involved in the provision of health services. Let me therefore state what comprehensive health planning *is* and *is not*.

— It is *not* a government takeover. The law itself is clear on this point, with emphasis on partnership, on areawide planning, and in the involvement of the major health professionals and community interests.

— It is *not* an activity limited to professionals. While professionals have vital roles to play, this is to be in concert with consumers. Comprehensive health planning officially recognizes that the end point of successful health care is the satisfaction and health of the consumer. To this end, consumers must be in the majority in the Advisory Council, and in the structure of areawide planning agencies.

IT *IS* a problem-solving mechanism whose potential uses and desirable structure at this time are not fully defined. For this reason, legislation to give statutory status to comprehensive health planning this year would be premature. Neither the Advisory Council nor the areawide agencies have had sufficient experience to determine statutory needs.

— Comprehensive health planning covers more than health facility planning and cannot be thought of solely in terms of its function in implementing the American Hospital Association's policy on reimbursement (to assure that third party payers provide capital expenditure funds to hospitals only for projects approved by an area-



AUTHOR
DOCTOR HUNT

wide planning agency). While the hospital issue is vital, the considerations of the Council must extend far beyond to the availability of services in communities, and to the quality of the physical and social environment, with the end point of success being improved health.

— Comprehensive health planning at the areawide level and at the statewide level will be compatible with the principles and objectives utilized for health facility planning under Federal grant programs in Michigan.

— Comprehensive health planning is not identical to "making a plan." It is erroneous, for example, to assume that through systems analysis alone, a plan for an area can be made involving locations of physicians and services and that once defined, the problem is automatically solved. Rather, the planning process involves intensive and often stressful interactions and negotiations between professionals and consumers in which it often becomes clear that the priorities of the consumers and the professionals are of quite a different order. Planning must be a continuing and dynamic process which, to be effective, must be at the local community level. Such planning, carried out through the areawide comprehensive health planning agency, cannot be controlled from any governmental or centralized agency, although guidance and financial help are most appropriate.

How, then, does comprehensive health planning at the state level proceed? While the role of the Advisory Council is in the process of definition, the Commission and the Council have agreed that the Council will review and advise on policies prior to their adoption by the Commission and will take the initiative in identifying areas in which planning recommendations should be developed by the Commission. The Council has already reviewed and endorsed the Commission's guidelines for the organization of areawide planning agencies and procedures with respect to health facility planning. Task forces are being organized to explore the areas of Comprehensive Personal Health Care, Health Care Costs and Organization of Services, Health Manpower, The Environment in relation to Health, and Health Data Systems.

The relationship between the areawide planning agencies and the State Commission is being clarified and refined. The Advisory Council will act as a catalyst for effective local planning and will serve as a forum for the assessment of problems and issues on a statewide basis.

MARMP Gains Momentum With Cancer-Heart-Stroke Program

BY ALBERT E. HEUSTIS, M.D., M.P.H.
MARMP COORDINATOR

A unique opportunity is offered to the health professionals and other people of Michigan, under the federal "regional medical program" legislation. Here, for the first time, the health professions have the opportunity to influence and, very literally, to control the expenditure of a significant federally financed health program designed to improve patient care.

The Michigan Regional Medical Program is endeavoring to stimulate: 1) identification of professional problems in the delivery of personal health services, 2) consideration of possible solutions, and 3) actions cooperatively agreed upon as offering the greatest chance of success. The approach to this broad, personal health care improvement is through the context of the care of patients with cancer, heart disease, stroke, and related diseases.

In a very real sense, the Michigan Regional Medical Program provides a framework for members of the health professions to cooperatively identify their "community health needs" and the solutions thereto. In this, an important factor is the development of comfortable and effective relationships between medical centers, community hospitals and other health institutions of the State. In this context then, the purposes of the program are to improve the actual care of patients through more effective uses of personnel, facilities and services, and scientific knowledge. Federal law is very explicit in prohibiting any interference with hospitals or physicians and, thus, whatever is done must be done on an entirely voluntary and cooperative basis.

THIS VOLUNTARY cooperative action is involved in taking a look at such things as: continuing education of the health professions, health communications, patient referral patterns, variances in the results of care provided by specific institutions, ways to more effectively utilize existing health manpower, and development of new types of health personnel. This approach involves the participation of an appropriate mix of health professionals, related scientists, community hospitals, medical centers, voluntary health agencies, and knowledgeable consumers. Subject matter committees have been meeting on various phases of the program and the results of their deliberations are available to those interested, or involved, in the health functional geographic areas of the State.



The Michigan Regional Medical Program is committed to being knowledgeable of, and trying to work cooperatively with, other health planning agencies in the State. Such actions will not only avoid unnecessary duplication of activity but will also add strength through complementary or supplementary activities.

WE ARE ENDEAVORING to build on resources that already exist and to strengthen them where indicated and necessary. There are, however, also concerns for innovations, accessibility and acceptability of services and facilities, plus a special concern for the personal health problems of the "deprived." In this, we are encouraging elements of the health care system to recognize both their needs and strengths — from whom they can comfortably gain and with whom they can comfortably share.

We face the year ahead confident that, through cooperative effort and honest self-evaluation, the cancer, heart disease, stroke, and related disease program will point the way for personal health services which provide even greater good for the patient and even greater satisfactions on the part of the health professionals.

NOTE: Inquiries concerning the "Program Plan," funded projects, or other information, may be addressed to the Michigan Association for Regional Medical Programs, 1111 Michigan Avenue, East Lansing, Michigan 48823.



AUTHOR
DOCTOR HEUSTIS

Michigan Hospital Association Observes 50th Year of Challenge

BY ALLAN BARTH
EXECUTIVE DIRECTOR
MICHIGAN HOSPITAL ASSOCIATION



This is the 50th year of the Michigan Hospital Association, and it is with anticipation that we look forward to the next five decades.

The significance of the hospital in the delivery of modern health services to large numbers of the United States' population has so increased in recent years that it is today the focal point for the provision of patient care. The modern hospital provides an institutional framework within which the modern health care team, composed of an unprecedented number of specialized professional and non-professional personnel, can effectively operate. Not only has the hospital emerged as the center of the delivery of health care services, but also it has become the major teaching milieu for the health profession. In addition to formal educational efforts, hospitals are encouraging continuing education and inservice training for all categories for hospital personnel.

ACCOMPANYING THE EXPANSION of patient care and educational programs has been an increase in the amount of research undertaken within the hospital setting. The complexity of the modern hospital environment is both a cause and a result of dramatic changes in medical research and practice.

These are tremendously challenging times for any group delivering hospital or health care service to the citizens of our state and nation. The solutions of the past no longer completely apply. We must look further and further to find the answers to the questions of how we can deliver better health care to more people.

With the help and cooperation of many others, the Michigan Hospital Association is exerting leadership in moving to meet the challenges intrinsic in the search for better health care, and it is actively developing new methods, new techniques and totally new processes to enable Michigan hospitals, big and small, to realize their manifest responsibilities.

Only by the free exchange of fact, knowledge and experience can the hospitals of Michigan effectively plan in a unified fashion for serving the hospital and health needs of future generations. With this goal in mind the association has developed its Hospital Information Center which will be the medium for the exchange and storage of all pertinent information of use to hospitals and health care facilities. The Hospital Information Center will be the repository of all the information of value gained by each association member hospital. This information will then be available as a collective information bank for the hospital, for the committee of the association and for anyone else having a legitimate use for the information.

WITH ITS FOCUS on the future, the Michigan Hospital Association is developing a new thrust in the direction of health facilities planning and financing. With intelligent planning and adequate financing the health care industry will survive the inflationary pressures being brought to bear upon it, by government and specialized interest groups whose influence at times has served to impede localized planning.

The Association is taking the larger view of planning for total benefit of the health care facility, the patient and the community, and is helping the local institution to fit into this overview. Recognizing the increasing difficulty being met by the local hospital in financing changes made necessary by growing demand for service, the Association, at the same time, is developing simpler and more available financing methods.

As hospital operation becomes more complex, it is obvious that a better method of administrative operation is and will increasingly be needed. The Association actively encourages the development of computer service systems which will give the smallest hospital the advantages heretofore



AUTHOR
MR. BARTH

available only to the largest, which will allow any sized facility the systematized progress made necessary by the ever-increasing patient-load and which will give to all health care facilities a computer service capability, if they desire.

Additional consultative services have been designed by the Michigan Hospital Association to compliment those services already in existence — such as legal, public relations, legislative and insurance. The newest of the consultative services are in the areas of personnel administration and management systems engineering.

One of the gravest problems to affect the health care industry today is the manpower shortage. The Michigan Hospital Association has joined with the State Board of Education in developing curricula for junior and senior high schools which will impart to the student the knowledge and skills necessary for employment in the health fields. The Michigan Hospital Association is also putting its own hospital career inducement material in the schools.

A SENSE OF SECURITY is one of the legitimate desires of most people. With this thought in mind, the hospital association has been a pioneer in developing hospitalization insurance, group insurance plans, pension plans, annuities, and other types of insurance applicable to workers in the health care industry. The popularity of all of these plans is not only the measure of their success but is the cause of intensified efforts by the association in the further development of other and more extensive insurance programs.

The Michigan Hospital Association is dedicated to helping its member hospitals maintain the same degree of excellence for which they have a notable reputation as well as to help them attain their fullest potential in the face of the ever-increasing demands for more service.

As a part of the "health care team" we extend our fullest cooperation to all others involved in the age old struggle to make of this earth a better place in which to live.

Michigan Nurses Association Observing 65th Anniversary

BY MRS. JOAN S. GUY, R.N.
EXECUTIVE DIRECTOR
MICHIGAN NURSES ASSOCIATION

May holds special significance for members of the Michigan Nurses Association. Registered nurses will join neighbors and friends in the activities of Michigan Week. They will take special pride in commemorating Michigan Nurse Week (May 4-10) and will celebrate the 65th birthday of the founding of MNA by dedicating the new MNA building in East Lansing – the first permanent home of the organization.

Birthday celebrations can become sentimental, rather maudlin occasions, particularly when a lady passes into middle age. Society places little value today on individuals or organizations who dwell on past events. Keeping pace with current changes precludes any preoccupation with last year's experiences or achievements.

The expectation of good health as a right, rather than a privilege in this country has placed heavy responsibilities on all members of the health team. The increased demand for health services has necessitated innovation in educational preparation of health practitioners, in the system through which services are rendered and in the relationships of workers in the health field.

SOCIETAL CHANGES have prompted the MNA to place priorities on four areas of activity. These are 1) the involvement and increased participation of qualified registered nurses in comprehensive health planning at the state and local level, 2) increased activity in planning and coordinating continuing education opportunities for R.N.s in Michigan, 3) better defining the scope of nursing practice, particularly as it relates to the practice of other professionals, and, 4) encouraging registered nurses to become more aware of and involved in social issues and community needs.

MNA will continue to assist nurses to improve their economic status and working conditions so that we can retain current practitioners, encourage inactive nurses to re-enter the field and recruit qualified students into the profession.

Another major goal will be to evaluate the utilization of R.N.s in all areas of employment. Statistics in Michigan and throughout the country indicate that there are more R.N.s per population today than ever before. At the same time, we continue to hear laments about the shortages of professional nurses.



IF REGISTERED NURSES were less involved in clerical, dietary, housekeeping, pharmacy, bookkeeping and "assistant hospital administration" functions, we might discover that the key to the so-called shortage is proper utilization of professional skills.

John Gardner writes that renewal within societal structures and organizations is crucial if an organization is to adequately and significantly serve individuals within the group. The Michigan Nurses Association seeks new perspectives and objectives in its pursuit of improved nursing care to the public and renewed sense of pride in the service rendered by nursing practitioners to their patients.



AUTHOR
MRS. GUY



MONTHLY SURVEILLANCE REPORT
CASES OF CERTAIN DISEASES REPORTED
TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
FOR THE FOUR-WEEK PERIOD ENDING MARCH 28, 1969

	1969 This 4-Week Period	1968 Same 4-Week Period	1969 Total To Above Date	1968 Total Same Date	Total Cases for 1968
Measles	28	41	74	111	352
Whooping Cough	22	45	41	130	429
Diphtheria	—	—	—	—	—
Mumps	658	1,875	1,636	6,797	14,655
Scarlet Fever & Strep Sore Throat	1,188	1,488	3,186	3,863	10,101
Tetanus	1	—	1	1	5
Poliomyelitis (Paralytic)	—	—	—	—	3
Hepatitis	267	135	750	424	2,356
Salmonellosis (Other than S. typhi)	35	62	102	147	614
Typhoid Fever (S. typhi)	1	—	1	—	1
Shigellosis	20	14	83	45	346
Aseptic Meningitis	10	7	28	18	265
Encephalitis	8	10	21	27	114
Meningococcic Meningitis	9	7	34	30	94
H. Influenzal Meningitis	3	4	10	14	64
Tuberculosis	184	262	571	775	2,647
Syphilis	326	371	1,134	1,416	5,351
Gonorrhea	1,316	1,186	4,253	4,161	18,153

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

1969 Maternal Welfare Conference Draws Large Crowd To Flint

BY JUDITH MARR
MANAGING EDITOR

The highly successful 1969 Conference on Maternal and Perinatal Welfare, staged March 26-27 in Flint, drew 136 more attendants than the 1968 meeting. Registrations totaled 489 for this year's conference, conducted in the Pick-Durant Hotel. Nearly half were nurses.

Robert D. Visscher, M.D., Grand Rapids, and Colin Campbell, M.D., Ann Arbor, led the program with discussions of "Who Should Receive Rh Immune Globulin?" and "Amniotic Fluid Analysis and Intrauterine Transfusion in the Management of Erythroblastosis Fetalis."

According to Doctor Visscher, a three-part study underway in Grand Rapids hospitals has been 99 percent effective in preventing Rh negative women from becoming sensitized after full-term and premature deliveries of Rh positive babies, if they are injected with Rh immune globulin within 72 hours after delivery and have not been sensitized previously.

Thus any such woman with full-term or premature delivery, should be injected, but injection is not necessary during pregnancy or after spontaneous abortions, he said. The dose used in Grand Rapids is 300 micrograms and no sterility or purity side effects have developed, he reported.

Doctor Campbell, who is part of an Ann Arbor team with 10 percent of the world's experience with intrauterine transfusions, reported the team has had 30 percent success in performing such transfusions and has limited them to patients with a history of still births or neo-natal death prior to 37 weeks of pregnancy, combined with a high-zone amniotic fluid analysis.

"In more recent years amniotic fluid analysis has become a standard procedure in helping the obstetrician know what to do when deciding whether or not his patient will require obstetrical intervention to prevent erythroblastosis fetalis."

Joseph W. Goldzieher, M.D., San Antonio, whose topic was "Myths about Oral Contraceptives," urged his audience to carefully analyze the data attempting to link cause-effect relationships to oral contraceptives and discussed how much of a patient's reaction to taking "the pill" can be due to her doctor's attitude in prescribing them.

"No one man in his office can really form a valid opinion of a pill's effectiveness," said the doctor. "And often printed things are ignorant and dishonest or the result of what I call 'medical McCarthyism' or 'guilt by association.'"

In his banquet address, Alan F. Guttmacher, M.D., New York City, president of Planned Parenthood-World Population, stressed that the home is the Number 1 bulwark for sex education, but that the subject can be supplemented in the school. Every teacher, every day in every subject should be able to help develop good sexual attitudes, he said. He advocated teaching sex education in the fifth grade, eighth grade and again in the high school. Physicians should help the high school youth to develop a good code of sexual responsibility, he said.

Murdina Desmond, M.D., head of the neo-natal section at Baylor University Hospital and coordinator for the Infant-Maternal Care Project at Jefferson Davis Hospital, Houston, emphasized that a newborn baby is handled by obstetrical, anesthetic and pediatrics departments and that good communication between the three is vital. In a recent study of babies born in Houston, one in four had some trouble. Yet much of the trouble is temporary, she continued, and "the big question is not what is wrong, but is this a sick baby?"

John W. Huffman, M.D., Chicago, author of *The Gynecology of Childhood and Adolescence*, stressed the importance of a routine genital examination of young girls under 16 years of age. "Young girls have every type of genital disorder that may afflict adult women," he stated.

Bradley E. Smith, M.D., of Miami, Fla., chairman of the American Association of Anesthesia's Committee on Obstetrical Anesthesia, closed the Flint conference with a discussion of "Analgesics, Anesthetics, Potentiators Used — Pre and Intrapartum."

"Of 14 million anesthetics administered annually in the U.S., three million are administered in the delivery room," said the doctor. "Very few of those are attended by an anesthetist and it is therefore important for physicians and nurses in the delivery room to have an even greater knowledge of the dangers of anesthetics and their use than other persons in the hospital.

"Anesthetics are not the most important thing in reducing maternal mortality," he continued. "But 90 percent of maternal deaths due to them can be prevented and the majority of neo-natal mortalities in the first and second day are due to them."

Photo Highlights Of The Maternal Welfare Meeting



Three participants who paused for a portrait on the mezzanine of the Pick-Durant Hotel in Flint, scene of the conference, were, from left, Joseph W. Goldzieher, M.D., San Antonio, Texas; Robert D. Visscher, M.D., Grand Rapids, and John W. Huffman, M.D., Chicago.



EDWIN C. GALSTERER, M.D., Saginaw, was cited at the conference by James E. Harryman, M.D., chairman of the MSMS Maternal Health Committee, as "one of the most faithful members in attendance. In his area he has worked diligently and his counsel is sought most eagerly concerning subjects in which he has no peer."



CHARLES M. BELL, M.D., Grand Rapids, was honored by the MSMS Maternal Health Committee at the Maternal and Perinatal Conference for his accomplishments as one of the committee's oldest members from the standpoint of service.

KEYNOTE SPEAKER of the Eighth Annual Maternal and Perinatal Welfare Conference which convened March 26-27 in Flint was Alan F. Guttmacher, M.D., New York City, right, president of Planned Parenthood-World Population. He was introduced following the evening banquet by Frederick F. Margolis, M.D., Kalamazoo, banquet chairman.





THESE UPPER PENINSULA doctors didn't let one of the snowiest and iciest days of southern Michigan's winter get in their way of conference attendance. Leaving at 5:30 p.m. the day preceding the meeting, they arrived at 3 a.m. in Flint. From left at the registration table as Helen Schulte of the MSMS staff greeted them, are William LeMire, III, M.D., and Raymond C. Hockstad, M.D., both of Escanaba, and James R. Dehlin, M.D., of Gladstone.

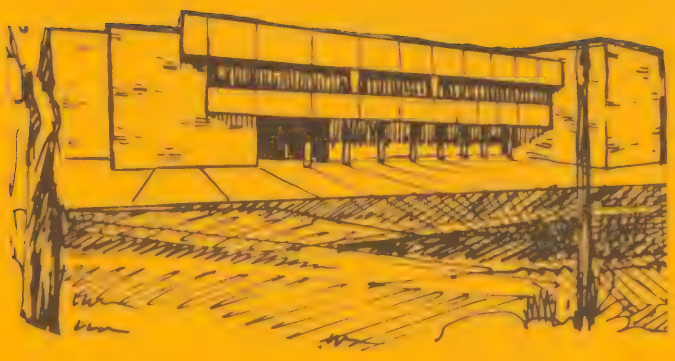
MATERNAL WELFARE CONFERENCE, CONT.



Northern Hospitality was extended to speaker Bradley E. Smith, M.D., of Miami, Fla., when he arrived in Flint. Greeting him were at left, James E. Harryman, M.D., Muskegon, chairman of the MSMS Committee on Maternal Welfare, and Jack W. Thompson, M.D., Flint, conference chairman for the third consecutive year.

HIGH INTEREST in the conference discussions was registered by this quartet. From left they are Lolita Rana, M.D., chief resident in obstetrics and gynecology at Hurley Hospital, Flint; R. F. Goins, M.D., Detroit; George Chamis, Mott Foundation, Flint, and Murdina Desmond, M.D., Houston, Tex., a speaker on the second day's program.





Towsley Center Dedicated at UM



Several hundred leaders in medicine and education attended the Dedication Ceremony for the Towsley Center for Continuing Medical Education at the University of Michigan March 27. The Dow Auditorium, shown above, will seat 518 in the attractive, functional Center erected at a cost of $2 million. The auditorium and classrooms are equipped with the latest in closed-circuit television and audio-visual facilities.



Early plans for the U-M continuing medical education center were started a decade ago by John M. Sheldon, M.D., then chairman of the PG department, and his assistant Doctor Towsley. The Center now features a Sheldon Lecture Hall and a portrait of Doctor Sheldon, unveiled at the dedication by Mrs. Sheldon. Doctor Sheldon died in 1967.

The Towsley Center was made possible by gifts from the Harry A. and Margaret D. Towsley Foundation and the Herbert H. and Grace A. Dow Foundation. Mrs. Towsley unveiled the Towsley Center plaque, and Doctor Towsley, chairman of the U-M Department of Postgraduate Medicine, gave the major address at the dedication.





THE NEWS CONFERENCE with Denton A. Cooley, M.D., Beaumont Lecturer, who flew to Detroit only hours after his famed operation in Texas, drew all the Detroit TV and radio stations and all the newspapermen from the Detroit papers and the wire services. Doctor Cooley, seated at right, fielded the many questions with ease.

DOCTOR COOLEY'S IN TOWN!



CONRAD R. LAM, M.D., right, chairman of the WCMS Beaumont Lecture Committee, introduced Doctor Cooley, who described efforts to maintain his patient, Haskell Karp, with an artificial heart until it could be removed for a heart transplant during a second operation.



DOCTOR COOLEY, Baylor professor of surgery, visits with Wayne County Medical Society President James C. Danforth, M.D., left, and MSMS President James J. Lightbody, M.D., right. This was the 48th annual Beaumont Lecture sponsored by WCMS.



REVIEWING THE BEAUMONT Lecture program are, left to right, MSMS Speaker James B. Blodgett, M.D.; WSU Professor Richard J. Bing, M.D.; Doctor Cooley, and WSU Associate Dean Alexander J. Walt, M.D. There was standing-room-only for the lecture, April 7.

Legislative Workshop Draws Auxiliary Members



STATE REP. William P. Hampton (R-Birmingham) welcomed members of the MSMS Woman's Auxiliary to their recent Second Annual Legislative Workshop in Lansing. Rep. Hampton urged the women, who were state auxiliary officers, county auxiliary legislative chairmen and others interested, to make their views known to their legislators.

A CHANCE to meet her own legislator was afforded each woman attending the workshop, like Mrs. Fred Swartz of Lansing, below, who chatted with Sen. Harold W. Hungerford of Lansing. The day's activities also included a visit to a legislative session.



AN INFORMATIVE TALK on pending medical legislation was presented by M. A. Riley, MSMS Legislative Counsel, second from right, at the MSMS Woman's Auxiliary Legislative Workshop. Planners of the program were, from left, Mrs. Philip Lange, Lansing, Legislative Workshop chairman and state legislative chairman for the Woman's Auxiliary; Mrs. Earl Weston, Birmingham, president of the MSMS Woman's Auxiliary, and Mrs. Justin Sleight, Lansing, president of the Ingham County Woman's Auxiliary to MSMS.



Careers Mobile Rolling





Sporting new exhibits and renovations, the Michigan Health Council's Health Careers Mobile went back on the road in March following two months in "dry dock." Its first appointment was in Detroit, and before it left its Lansing base, several staff members of the Health Council and MSMS gathered for a final inspection. From left in top picture, they are Ralph Wills, MSMS community relations director; Mrs. C. H. Mangelsdorf of Flint, MSMS Woman's Auxiliary Health Careers chairman; John A. Doherty, executive director, Health Council; John Hyde, Health Manpower coordinator, Health Council, and William Bressler, director of information and recruitment for the Health Council. In bottom picture Mrs. Mangelsdorf and Mr. Doherty inspect one of the new interior displays.



MICHIGAN STATE UNIVERSITY medical student Rex V. Barnes, left, is the winner of a $200 Medical Student Essay Award in Pharmacology from the American Society for Pharmacology and Experimental Therapeutics. Sharing his pleasure are his research advisors Drs. Jerry B. Hook, center, and John H. McNeill, assistant professors of pharmacology at MSU. The MSU student is among eight medical students selected nationally to win one of the annual awards. His came for a research paper in which he reported that the action of certain blood pressure-reducing drugs is dependent on the concentration of calcium present.



WARM GREETINGS were exchanged when MSMS President James J. Lightbody, MD, visited before a Detroit Economic Club luncheon with Stanley Kresge, Detroit businessman and benefactor.



Representatives from the Michigan Hospital Association met recently with the MSMS Committee on Hospital Relations at the committee's first get-together since its restructuring. Through their representatives at the meeting, the MSMS and MHA cemented their policy of cooperation, and discussed hospital regulations, comprehensive health planning, items of legislative interest, hospital inspection and ways to improve hospital efficiency. In bottom photo the entire group meets, while in photo at right those chatting are, from left, MSMS President-Elect Robert J. Mason, M.D.; Owen Pinkerman, MHA; Karl Klicka, M.D., chairman of the MHA liaison to MSMS, and A. C. Stander, M.D., MSMS Hospital Relations Committee chairman.





The site of the last state-owned and operated TB sanatorium to close its doors, Kalamazoo, is pinpointed on a Michigan map by John Isbister, M.D., left, of the Michigan Department of Public Health, and J. Irvin Nichols, executive director of the Michigan TB and Respiratory Disease Association.

Last State-Owned TB Hospital Closed

The same factors which have brought about the closing of the last state-operated TB sanatoriums in Michigan are also bringing the private physician into a more active role in TB containment and treatment.

James Isbister, M.D., chief of the Bureau of Community Health, Michigan Department of Public Health, pointed out the relationship in a recent interview as he discussed the significance of the closing of the hospitals.

The changing pattern of TB control, which includes the use of the prophylactic, Isoniazid, has made it possible for physicians to help in the treatment of patients, without having the patient hospitalized, and "provides the opportunity for the physician to become a more active participant in the program than he was in the past," commented Doctor Isbister.

"The private physician's role in the treatment of patients with the disease is enhanced when he accepts a patient discharged from the hospital for the continuation of medication at home," continues J. Irvin Nichols, executive director of the Michigan TB and Respiratory Disease Association.

"There will always be a need for some institutional care," said Doctor Isbister. "But it is entirely possible that all the short term care can be done in general hospitals.

So much more can be done by the private physician because he can prescribe the drug, and because it is more economically feasible for him to take the case, with the shorter treatment periods and health insurance plans, both men pointed out.

The state went into the sanatorium business in order to provide facilities where none were otherwise available or unsatisfactory buildings needed to be replaced, said Doctor Isbister. But as the number of patients declined and the period of treating them shortened, the sanatoriums were not being used to maximum, so the decision was made to close them, explained Doctor Isbister.

The peak load was in 1950, when 5,000 Michigan patients were hospitalized, many of them for two or three years. Now 2,000 patients are treated per year, but the average hospitalization is just 180 days.

The last eight tuberculosis patients were released in mid-March from the Southwest Michigan Sanatorium at Kalamazoo, the last to be operated by the state. Twelve city-owned and county-owned hospitals continue to provide care.

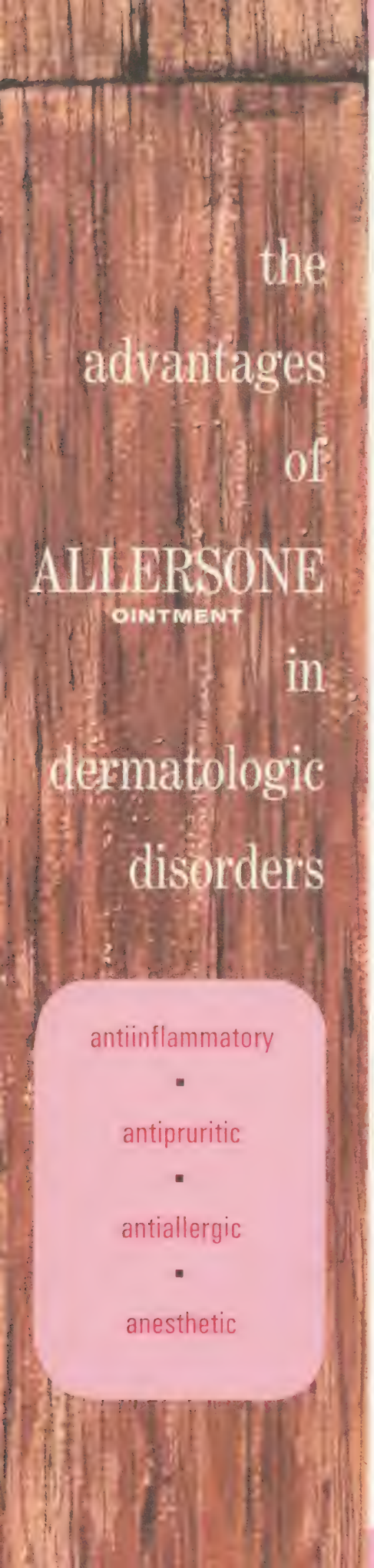
Though the recovery period for the TB patient is still long, the out-of-hospital treatment program is what makes the in-patient stay shorter now, said Mr. Nichols. "State government is delighted with the fact that TB control has reached this point, permitting closing of its facilities," added Doctor Isbister.





Two of the formerly-state-run TB sanatoriums which are all now used for other purposes, are the Northern Michigan State Tuberculosis Sanatorium at Gaylord, top picture, and the Michigan State Tuberculosis Sanatorium at Howell, bottom picture. The other sanatoriums were located at Hancock and Kalamazoo. There are still currently about 900 TB patients in 12 city and county-owned sanatoriums.


In dermatologic disorders...



IN THE MANAGEMENT of common dermatologic disorders, ALLERSONE provides more than symptomatic relief for your frustrated patient. Because ALLERSONE combines the antiinflammatory, antiallergic and antipruritic action of hydrocortisone with the anesthetic effect of diperodon HCl, it can make a worthwhile contribution to your therapeutic regimen.

ALLERSONE has long provided safe, effective and economical therapy for the anxious patient plagued by dermatologic problems. In addition, it is greaseless, odorless, colorless, as well as washable; thereby assuring a high degree of cosmetic acceptance.

ALLERSONE
OINTMENT

for effective topical management

COMPOSITION: Representing: Hydrocortisone 0.5%; Diperodon Hydrochloride 0.5%; Calamine 2.5%; Zinc Oxide 2.5% in a water-washable base containing sodium lauryl sulfate, propylene glycol, cetyl alcohol, white petrolatum, methylparaben and propylparaben as preservatives and water.

INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertrigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

ACTION: Hydrocortisone exhibits marked antiinflammatory activity when applied topically to the skin. It is ameliorative in pruritic, allergic and atopic skin lesions. Diperodon hydrochloride is a surface anesthetic, while the calamine and zinc oxide powders are well-known for their mild astringent and protective actions. The remaining ingredients comprise the water-washable base.

DOSAGE AND ADMINISTRATION: Distribute a small amount by gentle application over affected area, two or three times a day; frequency of application to be reduced with improvement.

CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain —while hydrocortisone reduces inflammation—in a water-washable vehicle —no desquamation from fats.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: 0.90 Allersone, pink ointment, available in 15 Gm. tubes and in pound jars.

MALLARD, INC.
PHARMACEUTICAL MANUFACTURERS
DETROIT, MICHIGAN 48216



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

No two women are quite alike...





and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-1



ANCILLARY

Doctor Pickett Lists Detroit Health Data

A recent report by George Pickett, M.D., Detroit-Wayne County public health director, to the Detroit Board of Health, included the following items:

1) The last Detroit diphtheria case and death occurred in 1966. Just eight cases and four deaths have been recorded in the past 10 years.

2) Only three whooping cough deaths were reported in the last 10 years, the latest in 1964. Cases total 679 reported annually.

3) The last two paralytic poliomyelitis cases in Detroit were reported in 1963, the last fatality in 1959.

4) Reported cases of measles dropped to an unprecedented low figure of 135 for 1968.

5) Only one case of tetanus was reported in 1968 and no deaths.

6) Smallpox has not been seen in Detroit since 1943.

7) Typhoid fever accounted for one non-fatal case in 1968, the last death occurring in 1950. Only 37 cases have been reported in the last 10 years.

8) The last human rabies case in the city occurred in 1939, and the last rabid animal, in 1965.

Eaton Labs Film Catalog Revised

A revised catalog listing 77 titles of surgical and medical science teaching films is available from Eaton Laboratories, Division of the Norwich Pharmacal Co. Included is a new series of six films dealing with uretero-pelvic juncture defect repair. Doctors interested may write Eaton Medical Film Library, Eaton Laboratories, Norwich, N.Y. 13815.

200 Children Examined In Health Survey

The third cycle of the Detroit area U.S. Health Examination survey conducted in March and April saw about 200 children, aged 12-17, called for physical examinations in the Health Survey's mobil examination center set up at the Dearborn Youth Center.

Household interviews, such as those conducted during the previous cycle in 1965, also were conducted. The six-week survey was conducted by David K. Oakley, field manager for the Public Health Service, from an office opened in the Veterans Administration Hospital in Allen Park.

The children were selected at random by a scientific sampling process. Purpose of the survey, authorized by Congress in 1956, is to collect statistical information on various aspects of the health of the youth of America and to obtain data on certain physical and physiological measurements relating to growth and development in this age group. It is separate from the National Nutrition Survey which was also underway in the Detroit area at the same time.

PATHOLOGISTS PLAN SEMINAR

"Cardiovascular Lesions" is the topic of a seminar to be conducted during the Michigan Society of Pathologists' meeting May 10 at Mt. Sinai Hospital, Detroit. Jesse E. Edwards, M.D., professor of pathology at the University of Minnesota, will lead the seminar.

Doctor Edwards, nationally renowned for his work in pathologic disorders of the heart and blood vessels, is also director of the program of training and research in cardiovascular pathology at Charles T. Miller Hospital at the University. He has been president of the American Heart Association and of the International Academy of Pathology and is author of a three-volume "Atlas of Acquired Diseases of the Heart and Great Vessels," published in 1961.

Lansing Doctors Take Part In Visiting Nurse Association

Three MSMS members are taking an active part in the Greater Lansing Visiting Nurse Association. Harold E. Crow, M.D., is a new vice president of the association, while Richard C. Melick, M.D., is a new board member. At the association's recent annual meeting, a certificate of thanks was presented to Martin F. Jones, M.D., in appreciation of his efforts on behalf of the visiting nurses. All three doctors are of Lansing.



Hot
under
the collar...

high under
the cuff.



Sometimes
he forgets he has hypertension, gets hot
under the collar...high under the cuff.

For such
patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6392

Time To Put AMA Annual On Your Calendar

That refreshing summer event — the Annual Convention of the American Medical Association — comes slightly later than usual this year. But once again the "AMA Annual" should figure significantly in advance planning of physicians.

The Annual Convention is the largest of the many meetings sponsored annually by the AMA. It covers so much of professional interest, and attracts so many physicians, members of allied health professions, industrial exhibitors, and guests, that only a relatively few cities have ample facilities to accommodate it.

THIS YEAR'S Annual Convention will be in the nation's largest city. Because the dates are July 13 through 17, it might be well to add that New York also ranks prominently in extent of air conditioning. But the Empire State's weather can be pleasant in July, and New York City also can benefit from any cool ocean breezes.

For the many physicians who take their families to the AMA Annual Convention, the New York City area offers many and varied attractions.

There is no question about the benefits for the physician. Among other things, there is opportunity to ask questions, discuss techniques and developments with experts, and enter into dialogue which no other means of medical communication allows so extensively and instantaneously.

FOUR GENERAL scientific meetings are offered, as well as 23 section programs (with the Section on Special Topics offering six sessions), breakfast roundtables and fireside conferences.

Additional postgraduate education is available through the exhibits, medical motion pictures and scientific television presentations.

This might be an excellent time — not a moment too soon — to put down those dates (July 13 through 17) on your calendar, talk to the family about going to New York together, and start planning reservations and other details. The American Medical Association's 118th Annual Convention will be here before you know it!

SIX NEW RADIOLOGY FELLOWS

Six Michigan physicians were made fellows of the American College of Radiology at the 1969 annual meeting. They are Kenneth D. McGinnis, M.D., Detroit; Donald R. Bryant, M.D., Flint; James A. Gunn, M.D., Grand Rapids; Clarence P. Chrest, M.D., Kalamazoo; Victor Curatolo, M.D., Mount Clemens; and Leland E. Holly, II, M.D., of Muskegon.

Fewer than 1200 of the 7000 members of the College have been awarded the degree of fellow.

HEALTH CAREERS MOBILE SCHEDULE

The Michigan Health Council's Health Careers Mobile has been on the road for several weeks. Its schedule so far this spring and for the coming weeks is as follows:

March 24-26 Wayne State University

March 27-April 11 Owosso High School and City of Owosso

April 14-18 Manistique

April 21-25 Holland Schools

April 28-May 2 Traverse City Mental Health Week

May 5-9 Bay City Hospital Week

May 19-23 Towsley Center for Continuing Medical Education, The University of Michigan, for Michigan Health Congress

May 26-30 Mt. Pleasant High School

June 3-7 Northeastern High School, Detroit

June 10-13 Grosse Pointe High School

June 16-20 Mt. Clemens Macomb County Services Week

Traverse State Hospital, MSU Human Medicine Begin Affiliation

The first step in the development of an affiliation between Traverse City State Hospital and Michigan State University has been carried out with the mutual appointments of officials at both institutions.

N. Duane Sommerness, M.D., superintendent, and Paul E. Kauffman, M.D., director of training and research at the state hospital, have been given medical faculty appointments at MSU, while Allen J. Enelow, M.D., chairman of the MSU Department of Psychiatry, and Donald Weston, M.D., MSU assistant professor of psychiatry, have been named consultants at the hospital.

Doctor Sommerness is an associate clinical professor and Doctor Kauffman an assistant clinical professor of psychiatry at MSU.

Under the new agreement, MSU medical students will receive specialized instruction in psychiatry at the state hospital and Doctor Sommerness and Doctor Kauffman will occasionally come to MSU to instruct medical students.

Doctor Sommerness is president-elect of the Grand Traverse-Leelanau-Benzie Medical Society and Doctor Enelow is also an MSMS member.

U-M GYNECOLOGIC SOCIETY ELECTS MSMS MEMBERS

News from the Norman F. Miller Gynecologic Society at The University of Michigan includes the naming of three MSMS members as society officers and a thank you from the retiring president for funds contributed by MSMS members to the Norman F. Miller Scholar Fund.

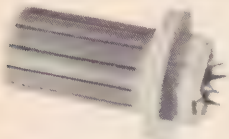
Among the new officers are David G. Anderson, M.D., secretary; David H. Middleton, M.D., treasurer and F. Wallace Jeffries, M.D., council member. George W. Morley, M.D., is immediate past president. All four are of Ann Arbor.

Wrote Doctor Morley in a recent letter to MSMS, "I wish to take this opportunity to thank those members of the State Society who made contributions to the Norman F. Miller Scholar Fund which has been established to perpetuate scholarly achievement through a young physician desiring a career in academic obstetrics and gynecology. We continue to request your help in this way."

Contributions may be forwarded, according to Doctor Morley, to The Norman F. Miller Scholar Fund, c/o J. Robert Willson, M.D., professor and chairman, Department of Obstetrics and Gynecology, University of Michigan Medical Center, Ann Arbor 48104.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

U-M Regional Drug Info Center Now Year Old

Since its opening one year ago, the Michigan Regional Drug Information Center at the University of Michigan Medical Center has served more than 500 Michigan doctors with information on the identification, availability and side effects of the nation's drugs.

The information center, located in the U-M Hospital Pharmacy, is open 24 hours a day, seven days a week to answer calls from doctors, dentists, pharmacists, nurses and other medical personnel. Since it opened in 1968, more than 1,300 requests for information have been answered.

The center clarifies drugs and offers more specific information on them for prescribing, lists the variety of drugs available for treatment and locates sources of certain drugs. Established under a grant from MARMP, the center is currently operating as a pilot program. Plans are for sub-centers to open around the state.

THREE PHYSICIANS SPEAK AT NURSES' SEMINAR

Three medical doctors were among the speakers at the Nurses' Seminar on Respiratory Diseases sponsored April 17 at Michigan State University. They were John L. Isbister, M.D., Chief, Bureau of Community Health, Michigan Department of Public Health; George C. Bower, M.D., Associate Physician, Division of Pulmonary Diseases, Henry Ford Hospital, and Tom M. Johnson, M.D., Associate Professor, Michigan State University School of Medicine.

The program was sponsored by the mid-Michigan district associations of the Michigan Nurses Association, the MSU School of Nursing, the Ingham and Jackson County TB-RD Associations and the Michigan TB and Respiratory Disease Association.

MICHIGAN RESPONSIBILITY OF NEW ASS'T SURGEON GENERAL

Vernon J. Forney, M.D., director of the Chicago Regional Office of the Health Services and Mental Health Administration of the Public Health Service, has been promoted to the rank of Assistant Surgeon General. Doctor Forney is responsible for the direction of public health programs in Illinois, Wisconsin, Michigan, Ohio and Indiana for HEW.

Smiles speak louder than words

for the good taste of Soyalac

Milk-free, hypo-allergenic Soyalac has a pleasing taste that is eagerly accepted by most infants. It's similar to mother's milk in composition and assimilation, much like cow's milk in consistency and completely free of fibre. Extensive clinical data support Soyalac's value in promoting growth and development. Soyalac is also excellent for growing children and adults.



Available in
Concentrated Liquid or Powdered

Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.

Soyalac

a product of

LOMA LINDA FOODS

MEDICAL PRODUCTS DIVISION

RIVERSIDE, CALIFORNIA

Mount Vernon, Ohio, U.S.A.



INGRAM'S SERVICE DEPARTMENT

ALL FACTORY TRAINED MEN

We service Medical Equipment, Electrocardiographs, Basal Metabalors, Sterilizers, Autoclaves, Diathermy Outfits, Cutting Units, Ultra Violet Lamps, Hydro Therapy Units, Laboratory Equipment. ALL BURDICK, LIEBEL FLARSHEIM AND RITTER EQUIPMENT.

If you have any Service problems, please call us at TE 2-4444, ask for the SERVICE DEPARTMENT and we will gladly help in any way we can.

THE G. A. INGRAM COMPANY

4444 Woodward Avenue TEmple 2-4444 Detroit, Michigan 48201

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

DETROIT OFFICE: G. A. Triplett, R. K. Wind and J. K. Galloway, Representatives
27200 Lahser Road, Southfield 48075 Telephone: (Area Code 313) ELgin 3-4848 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative
422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477

With the broad Polycillin (ampicillin trihydrate) spectrum...



...you have a lot going for you in the wide range of bacterial infections.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. **Indications:** Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci). **Contraindications:** A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms. **Precautions.** Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis —150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

:11-1/2/00 **A.H.F.S. Category 8:12.16**

Polycillin®
(ampicillin trihydrate)

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

BRISTOL

The penicillin you use like a broad-spectrum antibiotic

now she can cope...



thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.

Public Enema No. 1





Claim the rewards of sparing your patients the tubes and tribulations of unpleasant enemas.

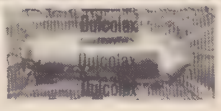
Compared to enemas, Dulcolax suppositories are a gentler and simpler way to empty the bowel. Gone are the tubing, the "accidents", and the bruised egos. Just one suppository, inserted against the bowel wall, usually brings about an evacuation within 15 minutes to an hour.

In the hospital, order Dulcolax for constipation or bowel cleansing. Your patients will often prefer it to embarrassing enemas. And you can be sure nurses will appreciate the saving in time and effort.

Dulcolax tablets taken at night usually result in a bowel movement the following morning. A combination of tablets at night and a suppository the next morning generally cleans the bowel thoroughly in preparation for surgery or special procedures. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable

bisacodyl



Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York 10502

DU-611

this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement
to facilitate healing
in chronic cutaneous ulcers...

Elase® Ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48168

Teamwork Needed In New Specialty, Says Dr. Feldkamp

BY LEE E. FELDKAMP, M.D., PRESIDENT
MICHIGAN ACADEMY OF GENERAL PRACTICE

An exciting new milestone has been achieved for those concerned with the provision of quality primary health care to our nation's people. It comes with the official recognition by the Advisory Board for Medical Specialties and the Council on Medical Education of the American Medical Association of a specialty board in family practice.

The development of limited specialties in the past 25 years has seriously hampered the educational efforts to supply the needed well trained physicians who would be concerned with family health care. Educational efforts were increasingly devoted to providing instruction in depth to the ever narrowing fields of special interest. Scientific developments dictated such instruction, but not the resultant neglect of the basic member of the team, the family physician.

Happily the evolutionary process has come full circle and the American public may look forward to the provision of family physicians who have a recognized opportunity to gain and demonstrate competence in the latest advances in medical science, on a level demonstrably equal to that of their colleagues in limited specialties. With this opportunity to gain equal recognition as a full member of the medical team, it is hoped that more graduates will be attracted to the field of family practice.

THIS RECOGNITION of family practice has come none too soon. Every estimate indicates a growing relative shortage of physicians of all sorts in the immediate future. There will be an increasing need for the skilled physician who understands the family unit and its health needs, the behavioral and environmental factors that influence it, and is himself equipped to provide top quality primary health care, while working effectively with his medical colleagues and with ancillary personnel needed to augment the health team.

The American Academy of General Practice, which spearheaded the move for adoption of the new board through the Section on General Practice of the American Medical Association, has been keenly aware of these needs, has provided educational opportunities for its own membership, and has moved to provide for the future.

Thus while the new family physician will have his origins in the earlier foundation of general practice, he will be taught to assume his role and enter the health team with demonstrated technical competence demanded by the advances of medical science and the growing needs of the American public. He will have a planned opportunity to learn what the skilled generalist of the past had to acquire by personal acumen.

WHILE FAMILY PHYSICIANS now in practice will be eligible to take the board examination upon completing 300 hours of accredited postgraduate study, a formal residency will be required of future applicants. The approved application for the new board incorporated a group of "Essentials for Graduate Training in Family Practice" as a guideline for the three year residency program. Periodic recertification, by examination, will be singular to the new specialty. The provision of approved residency programs within the guidelines will offer a challenge to the education directors of the hospitals.

Michigan is fortunate that the medical schools at the University of Michigan and at Michigan State University have demonstrated an awareness of the needs at the undergraduate level, and are moving in the direction of supplying the needed exposure and educational opportunity it is hoped will stimulate more graduates to enter this challenging field so necessary to the effective medical care of our people.

The challenge and need have been recognized. Teamwork by all of medicine will be needed for fulfilling the goal now defined.

Health Careers Ideas Suggested to Auxilians

BY MILTON R. WEED, M.D., CHAIRMAN
MSMS ADVISORY COMMITTEE TO
STATE WOMAN'S AUXILIARY

The Woman's Auxiliary to MSMS is a very active group in Michigan and deserves much credit



EDITORIAL VIEWS

especially for its work in the health careers recruitment field.

There is much that local and state Auxiliary units can do and there is much that they are doing across Michigan. Many Auxiliary members and units assist with Career Day programs in the schools, many help distribute materials, still others help with the Health Careers Mobile.

The AMA and MSMS recognize the need for more physicians and health persons in virtually every category.

LET ME SUGGEST several specific steps that every local Auxiliary unit and local member might take:

First, become knowledgeable about the health manpower problem, especially in your home community.

Second, assist in whatever way possible in organizing and stimulating committees on health manpower at state and county levels, both within the medical associations and within the Auxiliary itself.

Third, seek the cooperation of other interested groups, such as other health and medical organizations, hospitals and their auxiliaries, extended care and home care groups, voluntary health agencies, educational institutions, health planning bodies and – perhaps most important of all through your existing channels of communications – the public itself.

And fourth, to whatever extent is possible, or to whatever extent you are asked to help, assist medical societies in establishing positive leadership in these functions . . . in finding out what local needs are . . . and in determining how local needs can be met.

In general these four steps were suggested also by then AMA President-Elect Dwight L. Wilbur, M.D., at the 1967 national Auxiliary convention.

DOCTOR WILBUR DECLARED that "the entire medical profession needs to be able to look at the Auxiliary for assistance in recruiting people into the field."

I know that the state and local Auxiliaries in Michigan are active in many varied fields – Legislation, AMA-ERF fund raising, etc. – and these should be continued.

In addition to such fine accomplishments, the Auxiliary faces a challenge worthy of the organization to offer greater assistance – and leadership when asked – in the health careers recruitment field.

Cooperative Education In Health Occupations

BY LOTTIE WATERMAN, R.N.
CONSULTANT, HEALTH OCCUPATIONS
MICHIGAN DEPARTMENT OF EDUCATION

"It is imperative that, while bringing the three 'R's' to more people, education about the big 'H' – health – be included in our new plans for learning." This is a quote from page 63, "Health Is A Community Affair," the April 1966 report to the people of the United States by the National Commission on Community Health Services.

The report's chapter on Health Manpower emphasizes that "Comprehensive community planning for all health services – personal and environmental – requires that these problems become the concern of the doctor, lawyer, merchant, and chief; but the health professions must accept the greatest share of responsibility to improve health services, maintain quality care, and meet the needs of the entire community . . . to provide comprehensive community health services in the next decade will require unprecedented effort to recruit, educate, and train additional manpower for the health team. Such an effort should be intensive, planned, and continuous, and should emphasize teamwork among all levels of health manpower."

How shall we translate the Commission's studies into action? In February, 1967, our United States Commissioner of Education, Harold Howe, said to heads of State Departments of Education, "because of the resources offered by the Vocational Education Act of 1963 and the Manpower Development and Training Act to train health personnel, the mandate . . . falls on the educational community."

At the same time, Dr. Grant Venn, Associate Commissioner for Adult and Vocational Education wrote to the nation's state vocational directors about the critical area of health manpower. In part, he said, "I am appealing to you to help us in this serious situation by using your good offices, your persuasive powers, and your program authority to expand your state's health manpower training effort."

EVERY COMMUNITY could have a Health Occupations Education Program at the secondary level. Such a program is designed to offer health instruction, career exploration, and job preparation.

An occupational training plan known as Cooperative Education may be offered for students 16 years of age or over. It combines classroom instruction with supervised part-time employment for the Co-op trainee. This on-the-job experience fits abilities, aptitudes, and interests of the student. It permits earning while learning and opens the door of opportunity in more than 200 health careers.

But the school cannot do this job alone. The vocational integrity of occupational education for all students is strengthened by leadership from business and industry. With help from the community as a laboratory, cooperative occupational

(Continued on Page 516)



In Cervicitis

Help the healing process with StomAseptine® douching

Helps flush away exudates, maintain internal cleanliness, reduce odor...reassures the patient

StomAseptine douching is a valuable adjunct to cervicitis therapy. These gentle, non-irritating internal irrigations help maintain a clear field by washing away pus and secretions...relieve itching and burning...reduce malodor...and offer the patient a refreshing, reassuring procedure that can help speed the healing process.



Write for new booklet on patient douching instructions; space is provided for your specific recommendations. Advise quantity needed. Write: **Harcliffe Laboratories, Inc., Dept. 1003, 423 Atlantic Avenue, Brooklyn, N.Y. 11217**

STOMASEPTINE® DOUCHE POWDER

Contains: Sodium perborate, sodium bicarbonate, sodium chloride, sodium borate, menthol, thymol, eucalyptol, methyl salicylate and aromatics—Bottles of 6 oz., 15 oz., 32 oz., Cartons of 12, 10 Gm. Packets

education (school centered) in health occupations can have impact on improving quantity and quality of employees in the health services industry.

THE COMMUNITY laboratories or partners in this education process are legion, e.g., practitioner's office (physician, dentist, optometrist, osteopath, veterinarian, mortician); health service facilities (hospitals, clinics, nursing homes, extended care facilities), child care centers, public health agencies, voluntary health agencies, commercial medical, and dental laboratories; pharmacies, and health equipment supply centers. The employer who provides the laboratory is a concerned citizen who believes that he and/or his Board should be individually involved in a process that pays dividends in eventually producing people who want to help people.

Health services are the fastest growing industry. They must serve our socio-economic structure now evolving into a Human Resources Era which emerged in the early 1960's.

In the report "Health Is A Community Affair" a set of 98 recommendations supports 14 major positions, among them Health Manpower which receives the greatest number of recommendations. "Concerted efforts should be made to attract secondary school students to health careers by improving counseling, work experience in health facilities, and expanded work - study programs," emphasizes the report. Within a community any one of these, the school, the health facility, the health practitioner association or an auxiliary group has a responsibility for acting as the catalyst to urge action for these programs.

PHYSICIANS ARE CONSUMERS as well as producers of health service. Many physicians are also parents and members of school boards. Perhaps this professional group could emphasize the report's statement, page 64, that "State Departments of Education and local school boards should assume greater responsibility for the development of health curriculums."

In every K-12 program involving curriculum and facility construction, it is a community's concern to ask these questions:

1. How and where does the student get Health Services?
2. How do we promote and maintain Healthful School Living?
3. How and where do we meet the needs of students in Health Education?
4. How and where will they learn about Health Occupations?
5. Will they be able to learn one or more specific occupational skills in the health field as pre-employment training for a job in their community?

Today's students like to be where the action is. Co-op education in health occupations gives them the opportunity to be a part of the action in life and death situations. Is your community concerned and committed to this action?

More on Change . . .

(Editor's Note: This editorial is reprinted from the Oakland County Medical Society Bulletin)

BY GEORGE KINSLEY, M.D.
PONTIAC

Except for considerably more paper work, there seems to be no world-shaking change in the office and hospital practice of medicine as experienced by the solo practitioner. To most of us, the system seems fairly efficient with each physician having a full quota of "satisfied customers."

Nevertheless, the medical care system has come under increasing criticism in recent years from those individuals who are supposed to have a wider perspective — deans of medical schools, medical economists, medical administrators. Many feel that the system is creaking and needs reform. They cite, among other things, the uneven distribution of care, rising costs and hospitals duplicating each other's services. Many of these things, paradoxically, arise from medicine's phenomenal achievements in treating more and more diseases successfully and preventing others.

Health services have become the concern of every segment of society — big business, big unions, big government — and more people are becoming aware of and desirous of having medical services as a matter of right. Health services now rank as

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan — MU 5-8441

M. Leroy Barry, M.D.

Dan W. Everett, M.D.
Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

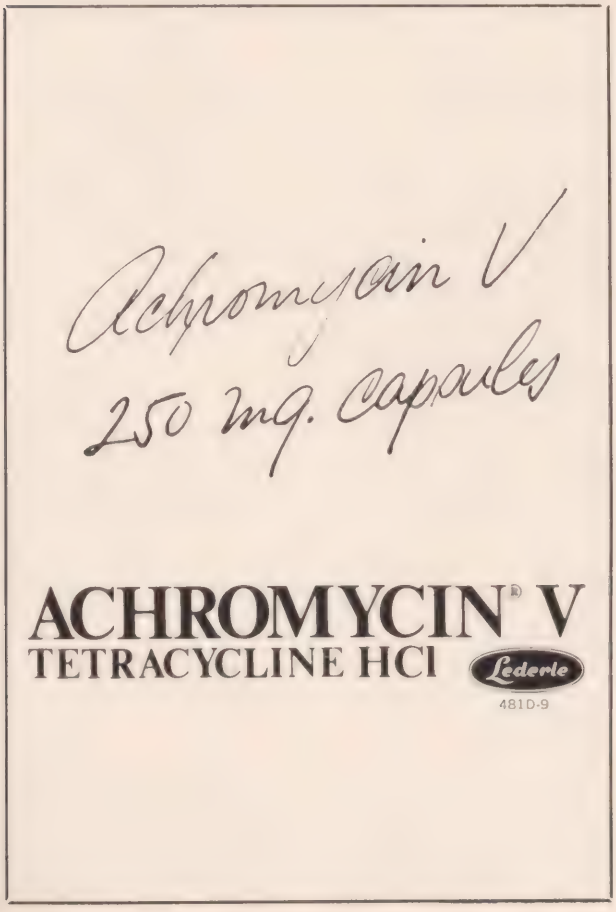
- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

the third largest employer of manpower in the United States and it is projected that by 1970 either the health services or education will be first.

The answers are coming from a number of sources. Some medical schools are streamlining their curricula and making them more flexible in order to satisfy the objectives of comprehensive medical care. The student is being trained and encouraged to become involved in social problems in response to the changes taking place. Medical Economists, as one example, Drs. Herman M. and Anne R. Somers, of the Brookings Institution "think tank," are recommending and predicting that by 1980 most doctors will be delivering care in huge hospital complexes equipped with massive outpatient facilities. They believe that there will be few solo physicians on the scene and that most hospital doctors will be on a salary or contract. We already see beginnings of this in the emergency room care and full time chiefs of services in hospitals around the country.

Along the same line, many medical administrators, in and out of government, believe and recommend that doctors must cooperate internally and provide medical services by group patient care as exemplified by the well-known group clinics around the country.

All in all, it seems that change, reform and revolution in medicine are in the air. In general, the future role of the individual physician appears to be as an important cog in the wheel but not as "the Wheel."





Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Recent attacks against the teaching of family life and sex education in public schools have been under the direction of the John Birch Society. These attacks claim such programs teach only "pelvic sex" and are part of a communist plot to undermine the morals of our youth. The Lay Education Subcommittee urges all physicians to speak out against these attacks when they occur in their community. Emphasis should be on the formation of good programs established by local committees of parents and teachers who select the type of program desired and the materials to be used in such programs.

Birch Society's Attack on Sex Education Answered by Three Major Articles

STRONG VOICE OF LOCAL PHYSICIAN MOST IMPORTANT

BY R. T. MELLIS, M.D., KALAMAZOO
CHAIRMAN, LAY EDUCATION SUBCOMMITTEE
MSMS COMMITTEE ON MATERNAL HEALTH

Within the last 3 months there have been concerted efforts in various parts of Michigan to discredit sex education in the public schools. There is every indication that these efforts will include the whole state and the nation and are sponsored by radical right wing groups of our society.

The Jan. 1969 Bulletin of the John Birch Society (Reprints available on request from MSMS Headquarters) directs members to establish MOTOREDE committees (Movement to Restore Decency). John Birch attacks have come through public meetings involving school issues, letters to the editor in local newspapers and public meetings with an outside "expert" guest speaker. The attacks are based on the premise that sex education in the public schools is part of a Communist plot to undermine the morals of our younger generation.

In many communities the strong voice of a respected local physician has been the deterrent to their success. It is difficult to publicly answer their charges, which include quotations taken out of context and isolated instances accumulated to make a point.

I wish to give Michigan physicians, through this article, some background information to answer the John Birch stereotyped attacks, to urge you to actively resist their attacks and to support good sex education programs in the public schools.

THE ATTACKS have been two-pronged. One is against established programs where the John Birchers make vague accusations that "in some classes" prurient things have been said or shown. The second attack has been directed towards SIECUS (Sex Information and Educational Council of the United States), both its board members and its publications.

As to the attacks against various established programs — it is of course easy to find isolated instances of "bad" sex education programs that are not locally supervised and controlled. The John Birchers refer frequently to slides shown to kindergarten classes showing men and women having intercourse. They are referring apparently to a slide program put out by the New York Teachers Association depicting the beginning of life from the birds and the bees, through animals to the last slide (listed as optional) showing a mother and father under a sheet in the position of having intercourse. Needless to say this set of slides has not sold very well.

It is important to realize that there are hundreds of films, slides, curriculum guides and printed materials available for use in sex education classes — and this is why we recommend that each school establish its own program and that teachers and parents jointly review materials used and supervise and screen the teachers conducting such classes. When the Birchers quote isolated instances of classroom occurrence — it is wise to ask for more detailed information of where and when those instances occurred.

The attacks on SIECUS and its board members are based primarily on guilt by association. Mary Calderone, M.D., executive director of SIECUS — is accused of being pro-Communist because her father was a photographer and her uncle, Carl Sandberg, the Lincoln poet. The implication is that anyone in these professions must be a radical leftist. She is also implicated because her husband (also a physician) is Chief Administrator of the World Health Organization — again with implication that this is a pro-Communist organization. Occasionally Dr. Calderone is quoted, but always out of context.

Isador Rubin, Ph.D., a former member of the SIECUS Board, receives the greater share of the attack because he was accused of being a member of the Communist Party from 1943 to 1951 and

because he is editor of a magazine called *Sexology*. The Communist party affiliation accusation was made in 1955 and never proved, coming during the time of Senator McCarthy's "investigations" during which many prominent people were also charged. This accusation was recently (June 1968) read into the Congressional Record as part of an article put out by the Birch-related "Herald of Freedom" publication, by Rep. John Rarick of Louisiana. Rep. Rarick recently lost his seniority as a Democrat in Congress because he actively supported George Wallace in the recent presidential elections.

The *Sexology* magazine Dr. Rubin edits is accused of being a pornographic smut magazine — while in actuality it is a serious attempt to provide sex education to adults. Its only criticism would be that it has added suggestive pictures to its title page and in its articles to increase its appeal to the general public.

The Rev. William Genne, another SIECUS board member, is also accused of being active in Communist front organizations. Actually he is coordinator, Commission on Marriage and Family, of the National Council of Churches of Christ in USA.

John Money, Ph.D., another SIECUS board member is questioned because he is a consultant on the *Sexology* magazine. He is associate professor of medical psychology and pediatrics at Johns Hopkins University.

Wardell Pomeroy, Ph.D., is another SIECUS board member who is implicated because he is also a consultant and contributor to the *Sexology* magazine. He is in fact a psychologist in New York, better known for his work with Dr. Kinsey as co-author of the "Kinsey Reports."

THESE MEN are all well known in their fields and employed by well known recognized institutions as well as being contributors to recognized scientific publications. Over 100 people have been on the board of SIECUS since its inception 5 years ago including presidents of medical schools, industries and insurance companies. Prominent Michiganders on the board have been Frederick Margolis, M.D., Kalamazoo pediatrician who has attained national acclaim for his movies in the sex education field and George Chamis, Ph.D., of Flint — who runs the Clara Elizabeth Fund sex education classes in the Flint Schools.

Defense arguments against these groups must emphasize several points.

(1) The AMA and the Michigan State Medical Society have both supported sex education in the public schools. The MSMS Lay Education Subcommittee has urged stressing the important points of a good sex education program as outlined by Dr. Margolis; that is, for each school to establish its own program with parent advisory committees helping outline the offerings, review and select the materials to be used and that the classes be extended to the adults of the community.

(2) As with any program of this nature there are likely to be abuses and extremes, particularly if parents are not involved in the control of the programs. From these "poor" programs examples can be taken to illustrate their points.

(3) There are a number of "curriculum guides" available (a number of these are available at MSMS headquarters for loan) to help schools and parents establish their program. The Michigan Department of Education has established a 19 member advisory committee, as set up in the 1968 Sex Education Bill (Public Act 44), which is currently meeting to set up "guidelines" for Michigan public schools, which should be available this fall.

(4) THE TEACHERS, of course, will be a crucial point in any program. We are not encouraging physicians to be teachers for the most part. The methods used, of course, must vary with the teacher. The elderly teacher might be more effective with an advisor-type program while the young teacher might do better with a "tell it like it is" type program. The source of good teachers is of course a problem, but in-service training programs are available and all state universities and colleges training teachers were instructed to establish sex education classes under Public Act 44.

In conclusion I would emphasize that these groups are determined and sincere as well as vocal. Do not make humorous remarks about them or their objectives as they turn these around to discredit your remarks.

The physician of course does have a responsibility. Anyone active in treating patients realizes the large number of patient problems related to inadequate sexual adjustments, not to mention illegitimate pregnancies, divorces and venereal disease. Of course the children will get their sex information someplace, so we are as interested as any parent in being sure our children get the proper information to help them in the formation of mature relationships. The Lay Education Subcommittee of the Maternal Health Committee will be happy to help you in any way possible.

BIRCHERS ATTEMPTING TO DIVIDE COMMUNITY — DOCTOR MARGOLIS

BY FREDERICK J. MARGOLIS, M.D.
KALAMAZOO

The *Bulletin* of the John Birch Society for January, 1969 came out urging its members to make an "organized, nationwide, intensive, *angry* (italics theirs) and determined opposition to the now mushrooming program of so-called sex education

in the public schools." (This *Bulletin* is the monthly directive to members sents out by Robert Welch, their totalitarian-type leader, who decides and dictates — without any vote by members — the society's policies and tactics.)

The *Bulletin* stated that the majority of the American people are not even aware of this filthy Communist plot among the sex educators. It stated that the leadership in this plot stems from SIECUS — the Sex Information and Education Council of the United States which is getting massive support from other *pro-Communist* influences in the American educational system, including, please note, the National Education Association, the National Council of Churches, the National Parent Teacher Congress and the United States Office of Education and the Office of Economic Opportunity.

The Birch Society is the same semi-secret organization that accused President Eisenhower of being part of the Communist scheme! It is already attacking President Nixon; Mr. Nixon, certainly considered a conservative and cautious man, has recently appointed Elizabeth Koontz, SIECUS member and National Education Association President, to the responsible and demanding position of head of the Women's Bureau of the Department of Labor.

Are we seriously to believe that these individuals and organizations are Communist or pro-Communist? Yet, while Birch Society members claim their purpose is to "fight Communists — nobody else" (Robert Welch's words), if we examine whom they attack by innuendo, misrepresentation, and distortion, we find that their targets are actually respected, long-standing organizations, agencies of our own government, and individuals and groups that represent a predominantly middle-of-the-road point of view.

THE FACT IS: Anyone or any group that disagrees with the Birch extreme-right point of view is labelled radical leftist or pro-Communist.

With reference to the attack on sex education, the Birch *Bulletin* implies that the sex educators are interested in "converting the present young generation into debilitated, directionless, unprincipled wastrels of their whole cultural inheritance," to make them easy targets for Communism! Without indicating persons or places, it accuses school teachers of setting up erotic situations and experiences for the children in the classroom, afterward asking them to relate these experiences. Can you honestly imagine any teacher you know conducting such a class? Or a school able to maintain the "cloak-and-dagger" secrecy among staff and students that would permit carrying out such a program?

The Birch Society description of sex education is, of course, in direct opposition to what the sex educator is attempting to do. There are several accepted guide lines that are essential for a quality sex education program in any school. These are:

1. A representative *community* group should study the concepts, philosophy, and materials available *before* deciding upon the advisability of initiating a program in its school system.

2. In terms of the community's general recommendation, the program content should be developed by the *local school system itself,* just as it develops other curriculum programs.

3. Adequate time for thorough study and teacher-training programs should be made available before any program is implemented.

4. As an essential part of the program in the school, all parents should be invited to consult with teachers, to read and view all materials, before they are used in the classroom.

5. For interested parents and to extend community interest and awareness, a similar program should be made available for adults.

If these safeguards are taken, there will be sufficient community understanding and involvement to safeguard and promote a quality program. It is through this kind of parent involvement that the real goals of supplementing and helping the home are achieved.

These are the guidelines encouraged by SIECUS, which continually emphasizes the importance of local development and control. This is exactly the opposite of the allegations made by its extremist opponents.

ALMOST A HUNDRED individuals have served on the large SIECUS Board in the last four years. Many of them are outstanding physicians: George Berry, former Dean of the Harvard Medical School; Harold Lief, Professor of Psychiatry at the University of Pennsylvania; Mary Calderone, who has spent years in the field of sex education. It is difficult to understand how the Birchers could accuse these individuals — and the numerous other outstanding persons who serve on the Board — of being part of a Communist "plot."

But irresponsibility is the hallmark of extremist groups of both the right and left. Both take one "correct" view and by un-American tactics in which "anything goes" if it will suit their ends, attempt to impose that point of view, that "line," on our democratic society. The true conservative, the true liberal, the true middle-of-the-road citizen, believes in substantiated facts and a cooperative effort toward resolving issues and solving problems. I would urge anyone interested in understanding the nature of the John Birch Society and other right-extremist collaborating groups to read Harry and Bonaro Overstreet's book, *The Strange Tactics of Extremism.* Their *What We Must Know*

About Communism explores the left-extremist areas.

Where have these attacks on SIECUS and the whole sex education program come from? To our knowledge, none of these attackers has had any training, background, or experience in sex education. In Allegan, Mr. Harmon Cropsey merely parrotted the Birch *Bulletin's* fear-provoking allegations. His qualifications as a speaker on this subject: ex-Cass county farmer; paid lobbyist for the arch-conservative organization, "Friends of Michigan Schools."

MAKE A POINT of examining the background history of Dr. Gordon V. Drake, currently on a "Christian Crusade" speaking tour which has brought him into several Michigan communities. Factual information is available from the National Council of Churches, the National Education Association's Commission on Professional Rights and Responsibilities, the national PTA. For instance, Dr. Drake has been a contributor to the Birch Society's *American Opinion* magazine. Also look into the question of who is sponsoring his appearances. Since the Birch Society operates cooperatively with other right-extremist groups, and also establishes many "front" committees and organizations, it is important to be alert to recognize these. To name a few front committees, there are TRAIN, TACT, Support Your Local Police, and MOTOREDE (Movement to Restore Decency). Other organizations create their own high-sounding names.

What is the real purpose behind this whole range of attack-tactics? The Birch group is not limiting its attack to the field of sex education. Similar irresponsible harrassment is being made on schools and local governments *in an effort to divide the community and frighten citizens into their camp.*

If there was ever a time when the inquiring mind of the physician could be useful to his local community it is in these times of extremism from both the right and left. I know of physicians from three local areas who have successfully confronted the Birch tactics at programs they have attended.

The schools will be the focus of attack in the future. Birch-influenced individuals have already attempted to influence materials and to harrass the teaching program in Kalamazoo area schools. We community members need to recognize and understand extremist tactics if we wish to sustain our democratic way of life and preserve the democratic process.

We *have* serious problems in our society today. We must meet these with a thoughtful, problem-solving approach instead of aggravating them with extremist divisiveness and negativism.

SAYS BIRCHERS FAIL TO RECOGNIZE VALUE OF HEALTH EDUCATION

BY E. C. GALSTERER, M.D., SAGINAW
MSMS MATERNAL HEALTH COMMITTEE

The recent protest against sex education in the public schools is one which exaggerates and misrepresents what the schools are trying to accomplish. The protesters imply that health education teachers are interested only "at the pelvic level," and it accuses teachers of setting up erotic situations and experiences for children in the classroom. It is next to impossible, in a community the size of Saginaw, where school teachers are our friends and our neighbors and people we know quite well, for any teacher to conduct the kind of class this criticism implies.

Our educational system is aimed at meeting the needs of young people in a rapidly changing society. One phase of this program is health education, a continuous program from kindergarten through the high school. Such a course includes a study of the human body, its structure and its functions, with special emphasis on diet, exercise and rest, on the effects of drugs, alcohol and smoking, and on the special teen-age problems of skin care. It also includes some instruction in first aid and emergency care. All these, you must agree, have value for any young people.

Somewhere farther along in this study plan comes a chapter on the understanding of interpersonal relations and the physical and emotional aspects on which this is based. Such subject matter is not unique to the school course of study. Ann Landers writes about it in the newspaper every day, and young people have interest in her column and respect for her opinions. The important thing is that young people today are more informed than the youth of previous generations. They are, on the whole, more sophisticated and experienced. Still, they are not always more accurately informed; and because they are so sure that they know everything, they are more than ever in need of honest and understanding guidance.

CRITICS OF SEX EDUCATION claim that this subject is being taught by "untrained instructors." This is partly true, since we are in a stage of transition. Yet, the same law, recently enacted, which permits instruction in the "aspects of family life and sexual relations," also provides for "educational programs . . . and inservice programs for instruction of teachers . . ."

What the John Birch Society, which has been most outspoken in this attack, fails to recognize is the value of this health education program as a whole. Sex education and interpersonal relations is only one small part of an overall program.

Yet this militant group has condemned the whole course of study. The Birchers have issued to parents a form to sign, providing that their children shall not receive *any instruction* in "sex and/or sexual attitudes, human and animal reproductive biological development, attitude development, self-understanding, personal and family emotional development, introspective examination of social and cultural aspects of family life, or group therapy or self-criticism" without their consent. This applies to "television, radio, slides, moving pictures, books, magazines, newspapers, or any printed publications whatsoever." Yet, those same young people go home and listen to TV all evening — and what do they see and hear? They go to the movies (at considerable expense) — and what do they see and hear? And they read any books and magazines they choose — and what kind do they choose?

Have those who condemn the school program taken any cognizance of the fact that our community plays a large part in planning such a course of study? Do they ever make an effort to participate in the planning? They *do* have the opportunity. No course is introduced into the public schools without the approval of the Board of Education — and their meetings are open to the public. Also influential are the PTA groups, which not only welcome all parents but plead with them to attend and participate in their meetings. Parents are also invited to preview any proposed health course and are asked to approve it or help revise it. Do those who protest ever attend such sessions?

THE JOHN BIRCHERS, in condemning these health education courses, place much blame on a national organization called SIECUS (Sex Information and Education Council of the United States), which they call "subversive" and "Communistic." Yet, this organization is being supported by the National Education Association, the National Council of Churches, the National PTA, the United States Office of Education and the Office of Economic Control. These accusers are the same who attacked President Eisenhower as a participant in a Communistic scheme. Is this group trying to help our society or to undermine our government?

Such critics are trying to divide communities and frighten citizens into "conservative action." But their scare technique, when aimed against the school system, is unrealistic. How can such extremely old-fashioned attitudes help young people of the modern generation, who, in their pseudo-sophistication, are already rebelling against a parent generation which has failed to "tell it like it is"?



Members of the Lay Education Subcommittee of the MSMS Maternal Welfare Committee, led by subcommittee Chairman Richard T. Mellis, M.D., Kalamazoo, right, are actively combating a John Birch Society campaign to discredit sex education programs in the Michigan public schools. With Doctor Mellis, above, are subcommittee members William C. Heitsch, M.D., Lapeer, left, and Laurence Bruggers, M.D., Saginaw.



The visiting Ann Arbor physicians were photographed, with members of the welcoming party upon their arrival at the Guam airport. In center, in print shirt with coat draped over his arm, is Doctor Barlow.

Doctor Barlow Reports on Guam Visit

Editor's note: The following is a first-hand account of the visit to Guam by eight Ann Arbor physicians. The author was the leader of the group.

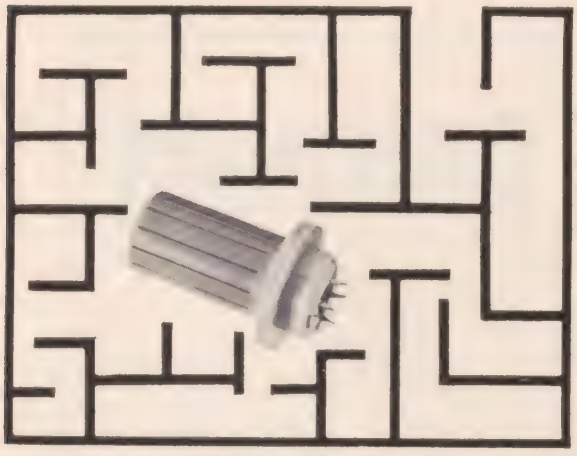
BY R. CRAIG BARLOW, M.D.
ANN ARBOR

Eight Washtenaw County physicians have recently returned from the island of Guam, where we conducted a week-long Medical Symposium, the first ever held there. We were invited by the Hon. Manuel Guerrero, Governor of Guam, and were guests of the civilian government of Guam. The physicians in our party and their special fields were: Jaroslav Bandera, M.D., pediatrics; R. Craig Barlow, M.D., internal medicine; Jerry Gray, M.D., pathology; Philip Hoskins, M.D., radiology; Robert S. Ideson, II, M.D., general practice and emergency room; Richard O. Kraft, M.D., surgery; David Middleton, M.D., obstetrics and gynecology; John Tipton, M.D., plastic surgery.

The Symposium was well received, the average daily attendance being 160, including civilian physicians, physicians from the Armed Forces, and physicians from the Trust Territory of the Pacific Islands. Additional people in attendance included Armed Forces nurses, and members of the Guam Nurses' Society. It is hoped that this Symposium will be only the first in a series of annual events.

In addition to the scientific program, we made progress in aiding the local group to form a stable medical society, perhaps affiliating with the Washtenaw County Medical Society as a "sister" society. One of the problems of organization on Guam is the fact that many of the physicians there are transient. This effort at organization is continuing.

The local group on Guam literally "knocked themselves out" entertaining the U.S. visitors. Social activities included a formal reception by the Governor, another by a Senator, a fiesta, visits to the Polaris sub base, to Anderson Air Force Base, the opening of the 10th Guam legislature, a reception by the Guam legislature, a reception by the Board of Guam Memorial Hospital, and more. We physicians left Guam with the warm feeling of having been welcome, well-received, and well-feted! We also felt that any similar invitations in the future would be readily accepted.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9



BRIGHTON HOSPITAL

A non-profit foundation

FOR ALCOHOLISM

Member, Michigan Hospital Association, American Hospital Association

A facility designed to rehabilitate and aid the compulsive drinker in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board.

12851 East Grand River
One block south of I-96 at Kensington Rd. Exit four miles east of U. S. 23
Brighton, Michigan
ACademy 7-1211

(A 16-m.m. sound color film on Brighton Hospital is available for free loan to qualified groups.)

---

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY
ANDROID — GOOD TO EXCELLENT 75%
PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android

Each yellow tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 10 mg.
Glutamic Acid . . . . . 50 mg
Thiamine HCL . . . . . 10 mg
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid . . . . . 50 mg
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . 64 mg.
Glutamic Acid . . . . . 50 mg
Thiamine HCL . . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (¼ gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
Glutamic Acid . . . . . 100 mg.
Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 . . . . . 2.5 mcg.
Riboflavin . . . . . 5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

also available with ESTROGEN

Android-E

Each Tablet Contains:
Methyl Testosterone . . . . . 2.5 mg.
Ethinyl Estradiol . . . . . 0.02 mg.
Thyroid Ext. (1/6 gr.) . . . . . 10 mg.
Thiamine Hydrochloride . . . . 10 mg.
Glutamic Acid . . . . . 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands

Write for literature and samples:
BROWN **THE BROWN PHARMACEUTICAL CO.**
2500 W. 6th St., Los Angeles, Calif. 90057

LEGAL

HOSPITAL PURCHASING CORPORATION HELD TAX EXEMPT

(Editor's Note: The following article is quoted from the AMA Citation newsletter of Jan. 1, 1969, prepared by the AMA Law Department.)

The personal property of a nonprofit corporation organized to make more efficient the purchasing of supplies for its member hospitals and that part of its real property used in its operations were exempt from taxation, a Michigan appellate court ruled. However, that part of the corporation's real property that it rented out was subject to taxation.

The statute provides for tax exemption of property owned and used by charitable organizations solely for the purpose for which they were organized and for exemption of property owned and used by a nonprofit organization for hospital or public health purposes.

The corporation's purpose is to develop charitable, scientific, and educational programs leading to improvements in hospital administration in order to assist hospitals to provide better hospital care at the lowest possible cost. The corporation is a nonstock organization. Only tax-exempt hospitals can qualify for membership in the corporation.

The corporation serves approximately 100 hospitals, 70 of which are members of the corporation. Its present operations are largely confined to the purchase, storage, and distribution of supplies to member hospitals and to other hospitals subscribing to its services. The operations are paid for primarily by the dues and service charges from the hospitals served. A slight mark-up is charged on the goods supplied in order to help defray operating expenses. The corporation incurred deficits in its first two years of operation, and the small profit realized in the third year was used to expand its operations.

Since all of the member hospitals were tax-exempt, the purchasing department of an individual member hospital, could not be singled out and subjected to taxation. Therefore, it would be unwise to interpret the statute so as to conclude that what is free from taxation when done by hospitals individually is subject to taxation when done by hospitals acting in concert. To so interpret the statute could have the effect of impeding an imaginative effort designed to reduce the cost of hospital care.

The fact that approximately 1600 square feet of its building is leased to the state for use as a drivers' license bureau did not make the corporation ineligible for exemption, even though the statute is in terms of "sole" use. To hold that a charitable institution would be ineligible for tax exemption because it leased a portion of its premises would be unreasonable, because circumstances may not permit the institution to obtain property exactly the size required to accommodate its needs. The reasonable interpretation is to subject to taxation only that part of the building that is leased.

Although the corporation was not competing in its operations with private noncharitable corporations, it would still be entitled to exemption if it were.

The fact that only a small fraction of the corporation's services would directly benefit the city where it was located and the citizens of that city had no bearing on the question of the corporations eligibility for exemption. — *Hospital Purchasing Service* v. *City of Hastings,* 161 N.W.2d 759 (Mich., May 29, 1968)

from Vol. 18, No. 6

NO LIABILITY FOR FAILURE TO DIAGNOSE PKU

(From the AMA Citation newsletter of Feb. 1, 1969.)

A mentally retarded child was denied recovery in his suit against two pediatricians for their alleged negligence in failing to diagnose his condition as PKU. A Michigan appellate court ruled that the trial court did not abuse its discretion in excluding the testimony of the child's expert witnesses from Chicago and Los Angeles on the ground that they were not qualified to testify as to the standard of care applicable in Detroit, where the alleged negligence occurred.

The witness from Chicago testified that commercial medicines and special dietary programs were available for children suffering from PKU throughout the time that the child was untreated. He also testified that tests for PKU were easy to make and were routinely made in the hospitals of the nation.

The witness from Los Angeles testified as to the dissemination of knowledge about PKU throughout the nation, both to pediatricians and hospitals. He stated the opinion that any certified pediatrician should have made a PKU test at the time that the child was under the care of the pediatricians.

Three Detroit physicians testified for the pediatricians. They stated that it was not common

practice for pediatricians in the Detroit metropolitan area to use the recognized tests for PKU at the time in question because the disease was so rare. They stated that the pediatricians did not depart from the usual standard of care of pediatricians in the area.

The jury returned a verdict of $80,000 for the child. The trial court set aside the verdict and entered judgment for the pediatricians. The reason given by the trial court for its action was that, since, the child's witnesses did not practice in Michigan, they could not be considered by the jury as worthy of belief regarding the actual standards of practice in the Detroit area at the time of the incident. The trial court further ruled that the evidence did not show that Detroit was a community "similar" to Los Angeles, despite the Los Angeles physician's belief that the existence of medical centers engaged in PKU research in both cities made them "similar." There was testimony showing that the general practitioners in the Detroit area did not know that the medical centers in the area were engaged in PKU research at the time in question.

The reviewing court said that it was somewhat disturbed by the fact that the pediatricians knew of PKU, its symptoms, and the tests to detect the disease at the time in question. However, this was not sufficient to overcome the evidence that they did not depart from accepted standards of practice in the community.

Under prevailing law, it could not be said that the trial court abused its discretion in excluding the testimony of the child's medical witnesses. Competent cross-examination and the testimony of the Detroit physicians to counter the assumptions of the Los Angeles physicians effectively showed that he was not familiar with the prevailing practice of pediatrics in the Detroit area and the area was shown not to be "similar" to Los Angeles. Although one might not be pleased with the level of thoroughness of Detroit area pediatricians at the time in question, the court said, it was the law of the state that a physician was not to be held to a greater duty of care than that expected of his fellow physicians in the community.—*Naccarato* v. *Grob,* 162 N.W.2d 305 (Mich., June 26, 1968; appeal granted, Sept. 10, 1968).

from Vol. 18, No. 8

TENTH ANNUAL MUSCLE SYMPOSIUM
AUDITORIUM WAYNE COUNTY MEDICAL SOCIETY
1010 Antietam Street, Detroit, Michigan
May 21, 1969: 8 a.m. to 5 p.m.
SCIENTIFICALLY OUTSTANDING ESSAYISTS

Peter S. Mueller, M.D., Yale University, **"The Use of Amitriptyline in the Treatment of Amyotrophic Lateral Sclerosis."**

Paul J. Vignos, M.D., Western Reserve University, **"Recent Developments in Muscle Disease."**

Charles Long, II, M.D., Western Reserve University, **"Recent Advances in the Application of External Power in Upper Extremity Paralysis."**

John Stirling Meyer, M.D., Wayne State University, **"Recent Advances in Diagnosis and Management of Problems Related to Muscle Tone, Muscle Weakness and Atrophy."**

Institute of Muscle Disease, Cornell Medical Center, N.Y., **"Electron and Light Microscopic Observations in Muscle and Nerve Disease"** Selected Staff Members.

Drs. R. Bauer, J. Gilroy, J. McHenry, M. Vulpe, J. Gotham, A. Ericcson, Wayne State University School of Medicine, Department of Neurology in selected topics involving Upper and Lower Motor Neuron Disturbances.

Sponsored by the Muscular Dystrophy Association of America, Wayne State University School of Medicine, Department of Neurology, Detroit-Macomb Hospitals Association. Max Karl Newman, M.D., Chairman.

IMPERIAL-AMERICAN RESOURCES FUND, INC.

Directors and Executive Officers:

Edward R. Annis, M.D., Director
Past President of American Medical Association

J. L. Burke, Attorney, Director
Past President of Service Pipe Line Company

Myer Feldman, Director
Partner in law firm of Ginsburg and Feldman

Joseph J. Foss, Director
President of Joe Foss, Inc.

Howard H. Hinson, Director
Former Vice President, Continental Oil Company

Stanley C. Hope, Director
Chairman of the Board of Struthers Thermo-Flood Corporation

Charles F. McCoy, Chairman of the Board
Past Secretary of Sinclair Oil Corporation

William H. Morris, Director
Former President of Sinclair Oil & Gas Company

Walter M. Schirra, Jr., Capt. USN, Director
National Aeronautics and Space Administration

Arthur J. C. Underhill, Director
Former partner of Arthur Weisenberger & Company

James A. Hanlon, Administative Vice President
Formerly with Sinclair Oil Corporation

Herbert C. Loth, Jr., Secretary
Partner in Law firm of Peterson, Lowry, Rall, Barber & Ross, Chicago, Ill.

David E. Melendy, Financial Vice President
CPA, formerly with Arthur Young & Company

ROYAL RESOURCES EXPLORATION, INC.

Directors and Executive Officers:

Edward A. Annis, M.D., Director
Past President of the American Medical Association

Paul D. Bagwell, Chairman of the Board
Past President of US Junior Chamber of Commerce

J. L. Burke, Director
Past President of Service Pipe Line Company

Myer Feldman, Director
Partner in law firm of Ginsberg and Feldman

Joseph J. Foss, Director
President of Joe Foss, Inc.

George C. Hardin, Jr., Director
Former Vice Pres. of Kerr-McGee Corporation

Stanley C. Hope, Director
Chairman of the Board of Struthers Thermo-Flood Corporation

Arthur J. C. Underhill, Director
Former Partner of Arthur Weisenberger & Company

Marvin R. Barnett, Financial Vice Pres.
Former Director Northern Natural Gas Producing Co., Omaha

Jackson M. Barton, Executive Vice President
Past Pres. Rocky Mountain Oil and Gas Association — Nebraska Section

Herbert C. Loth, Jr., Secretary
Partner in Law firm of Peterson, Lowry, Rall, Barber & Ross, Chicago, Ill.

David E. Melendy, Treasurer
CPA formerly with Arthur Young & Company

Before You Invest

Inquire About The Tax Saving Possibilities Of:



Imperial-American Resources Fund, Inc.



Royal Resources Exploration, Inc.

Imperial-American Resources Fund, Inc., conducts diversified drilling programs on proven and semi-proven properties.

Royal Resources Exploration, Inc., conducts diversified exploratory drilling programs.

WESTAMERICA SECURITIES, INC.

3655 28th. St. S.E., Grand Rapids, Mich. 49508

Please send prospectus and additional information regarding Imperial-American Resources Fund, Inc. and Royal Resources Exploration, Inc.

Name _____

Street _____

City _____ State _____ Zip _____

Phone _____

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

OFTEN... HER LOWER G. I. TRACT



Psycho-abdominal Distress: Frequently Female

Women aged 15 to 45 appear to be more prone than men to bloating, cramping pain of stress-related intestinal disturbances such as irritable or spastic colon.[1,2]

Frequently Recurrent

In the experience of many physicians, women are more likely to reappear time after time with repeated complaints of lower G.I. distress.

Requiring Definitive Therapy

Often needed is therapy adequate to control both the somatic and the emotional components of psycho-abdominal complaints.

Definitive Dual Therapy

'Milpath' contains a proven synthetic anticholinergic useful for relieving hypermotility, spasm, and hypersecretion of the gastrointestinal tract.

In addition, 'Milpath' provides a time-tested tranquilizer for mild but effective anti-anxiety action.

With Flexible Dosage

- 'Milpath'-400 (meprobamate 400 mg. + tridihexethyl chloride 25 mg.) Usual adult dose: 1 tablet *t.i.d.* and 2 at bedtime.
- **When less tranquilization is required: 'Milpath'-200 (meprobamate 200 mg. + tridihexethyl chloride 25 mg.)**

Wallace Pharmaceuticals/ Cranbury, N. J. 08512

gently but firmly

MILPATH®

(meprobamate + tridihexethyl chloride)

relaxes smooth muscle and psyche

Please see the following page for brief summary of prescribing information.

Gently but firmly MILPATH®

(meprobamate + tridihexethyl chloride)

Relaxes smooth muscle and psyche



Usual Adult Dosage

One 'Milpath'-400 tablet, three times a day at mealtimes, and two at bedtime. For greater anticholinergic effect, two 'Milpath'-200 tablets, three times a day at mealtimes and two at bedtime. Doses of meprobamate above 2400 mg. daily not recommended.

Indications

Useful in organic and functional disorders with hypersecretion and hypermotility of G.I. tract, especially when accompanied by anxiety, neurosis, or tension states. Should be used as an adjunct to all other therapeutic measures.

Contraindications

Tridihexethyl chloride: Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus: organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention.

Meprobamate: Previous allergic or idiosyncratic reactions to meprobamate.

Precautions

Tridihexethyl chloride: Use cautiously in elderly males (possible prostatic hypertrophy).

Meprobamate: Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (one or two weeks) after excessive dosage for weeks or months to avoid recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.

Side Effects

The following side effects of components may occur with 'Milpath'.

Tridihexethyl chloride: Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness.

Meprobamate: Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after one to four doses); in mild form: itchy, urticarial or erythematous, maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and one fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (one fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, one fatal aplastic anemia reported, but only in presence of known toxic drugs, porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by one observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported.

Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.

Supplied

In two strengths:

'Milpath'-400: Yellow, scored tablets.

'Milpath'-200: Yellow, coated tablets.

Before prescribing, consult package circular.

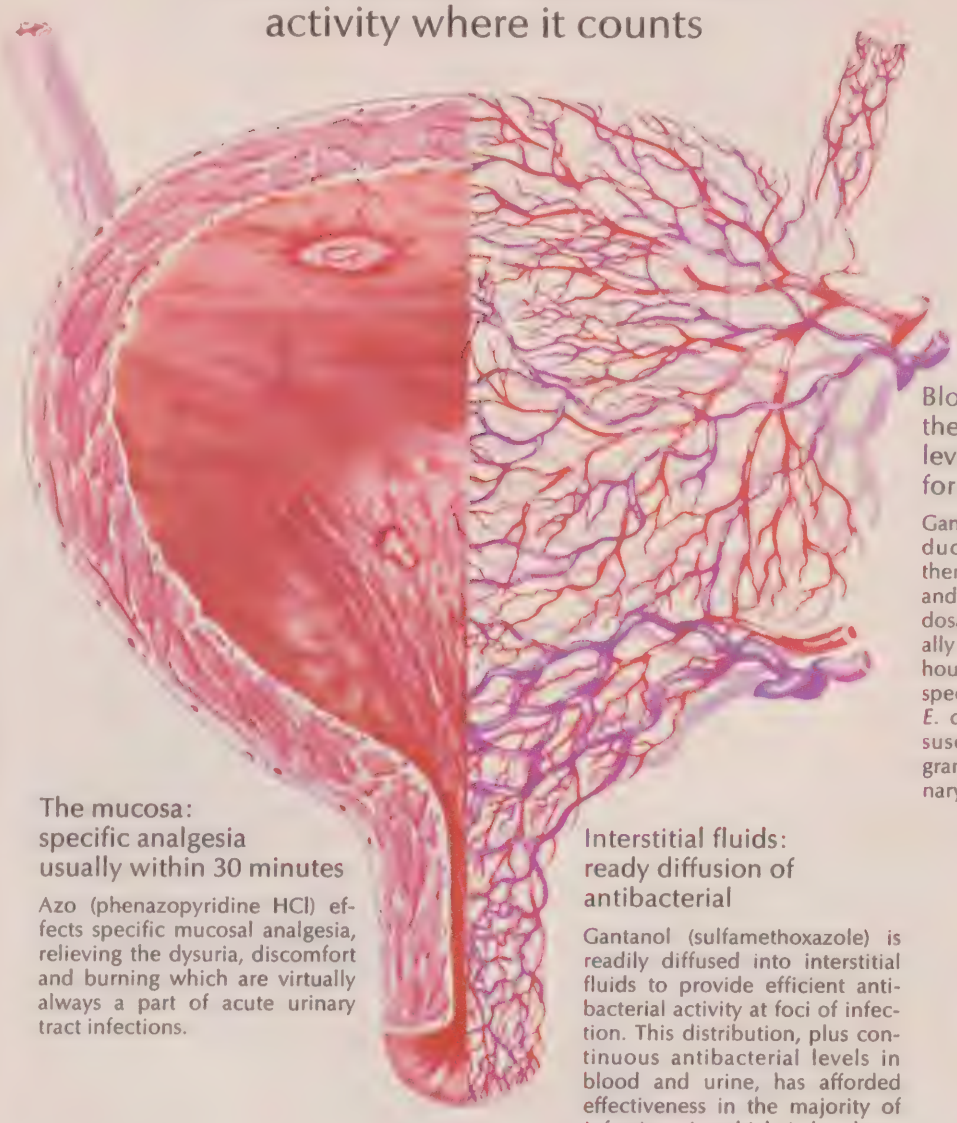
References

1. Harrison, T. R., et al.: Principles of Internal Medicine, Fifth Edition, New York, The Blakiston Division, McGraw-Hill Book Company, 1966, p. 1019. 2. Bockus, H. L.: Gastroenterology, Second Edition, Philadelphia & London, W. B. Saunders Company, 1964, Vol. II, p. 729 et seq.

(1928A01J)

Inner Sites...

In Cystitis...Azo Gantanol® focuses analgesic-antibacterial activity where it counts



The mucosa: specific analgesia usually within 30 minutes

Azo (phenazopyridine HCl) effects specific mucosal analgesia, relieving the dysuria, discomfort and burning which are virtually always a part of acute urinary tract infections.

Interstitial fluids: ready diffusion of antibacterial

Gantanol (sulfamethoxazole) is readily diffused into interstitial fluids to provide efficient antibacterial activity at foci of infection. This distribution, plus continuous antibacterial levels in blood and urine, has afforded effectiveness in the majority of infections in which it has been used.

Blood and urine: therapeutic antibacterial levels within 2 hours for up to 12 hours

Gantanol (sulfamethoxazole) produces prompt and prolonged therapeutic levels, in both blood and urine, with convenient *b.i.d.* dosage. Clinical response is usually obtained within 24 to 48 hours. The wide antibacterial spectrum of Gantanol includes *E. coli* and a variety of other susceptible gram-negative and gram-positive pathogens in urinary tract infections.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

ROCHE

Roche
LABORATORIES

Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)



Preludin® phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.

Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B)R3-46-560-B

Under license from Boehringer Ingelheim G.m.b.H.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

She runs a good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a curb on appetite and promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

A few patients may experience overstimulation or insomnia. For a brief summary of all adverse reactions, precautions, warning and contraindications, please see the adjoining page.

Preludin® phenmetrazine hydrochloride

Endurets® prolonged-action tablets

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

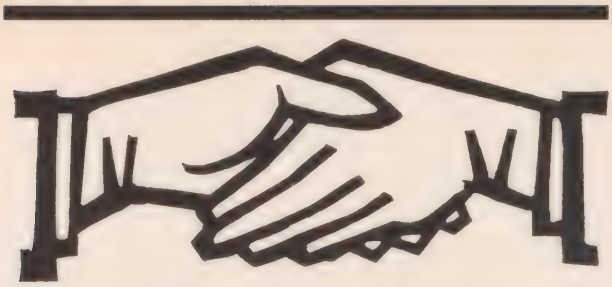
Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Anton Schwarz, M.D., 1006 Sterling Dr., Midland 48640
A. A. Sheperdigian, M.D., 421 S. Fancher, Mt. Pleasant 48858
J. Bernard Sloan, M.D., 3169 W. Pierson Rd., Flint 48504
Thomas C. Smith, M.D., 2800 Plymouth Rd., Ann Arbor 48105
John F. Stageman, M.D., 609 Harris Bldg., Jackson 49201
Zwi Steiger, M.D., V A Hospital, Dearborn 48121
Benjamin J. Stone, M.D., 1005 Abbott Rd., East Lansing 48823
Douglas B. Van Brocklin, M.D., 1300 N. Dort Highway, Flint 48506
David L. VerLee, M.D., 503 S. Saginaw St., Flint 48502
Watson A. Young, M.D., 3508 Harrison, Inkster 48141
Joel M. Bamford, M.D., 2132 N. Cedar St., Holt 48842
Roy E. Buck, M.D., 1405 E. Ann St., Ann Arbor 48104
Ricardo S. Centeno, M.D., Grace Hospital, Detroit 48202
Lawrence A. Danto, M.D., St. Joseph Mercy Hospital, Ann Arbor 48104
George Diaz, M.D., Lafayette Clinic, Detroit 48207
Wm. C. Donahue, M.D., University Medical Center, Ann Arbor 48104
Richard H. Jacobsen, M.D., University Medical Center, Orthopaedic Surgery, Ann Arbor 48104
Ray O. Lundy, M.D., Pontiac General Hosp., Pontiac 48053
James F. Murphy, M.D., University Medical Center, Internal Medicine, Ann Arbor 48104
James R. Sauer, M.D., 315 Hazelwood Ave., Ann Arbor 48103
Burt T. Weyhing, M.D., 18700 Meyers Rd., Detroit 48235
Mary K. Ansley, M.D., 1101 David Whitney Bldg., Detroit 48226
Jan W. Buettgen, M.D., 16800 E. Warren, Detroit 48224
Harry R. Butler, M.D., 1336 Southfield, Lincoln Park 48146
Wm. N. Davis, M.D., 1250 Middlebelt Road, Inkster 48141
Caesar DeGuistino, M.D., 1175 E. Grand Blvd., Detroit 48211
Angel G. Dizon, M.D., 18424 W. McNichols Road, Detroit 48219
Charles Egli, M.D., 312 E. Chisholm St., Alpena 49707
Emanuel Frisch, M.D., 1800 Tuxedo, Detroit 48206
James E. Galligan, M.D., 18471 Haggerty Road, Northville 48167
Hassan Ghandchi, M.D., 27549 W. Six Mile Road, Livonia 48152
Mehmet K. Goknar, M.D., Northville State Hosp., Northville 48167
A. Alberto Hodari, M.D., Crittenton Hospital, Detroit 48206
Joshua Hollander, M.D., Mental Health Research Inst., Univ. of Michigan, Ann Arbor 48104
Kenneth Israel, M.D., 10607 W. Seven Mile Road, Detroit 48221
Sidney B. Jenkins, M.D., 2617 W. Grand Blvd., Detroit 48208
Youn S. Kim, M.D., Box A, Kalamazoo State Hospital, Kalamazoo 49001
Cassandra M. Klyman, M.D., 20905 Greenfield, Southfield 48075
John G. Lipski, M.D., 603 East Lake Street, Petoskey 49770
Charles T. Louisell, M.D., 306 State Bank Bldg., Traverse City 49684
Paulino R. Luna, M.D., 10151 Michigan Ave., Dearborn 48126
Ivan J. Mader, M.D., 15 Elm Park, Pleasant Ridge 48069
Eugene S. Martinovsky, M.D., Northville State Hospital, Northville 48167
Thelma H. McQuiggan, M.D., 1250 Middlebelt Road, Inkster 48141
Lewis H. Milburn, M.D., 3800 Woodward Ave., Detroit 48201
Jahangir Mohtadi, M.D., 302 W. Main St., Northville 48167
Stephen K. Molnar, M.D., 4525 S. Telegraph, Dearborn 48125
Richard K. Muir, M.D., 4777 E. Outer Drive, Detroit 48234
R. William Neumann, M.D., 1414 W. Fair Ave., Marquette 49855
M. Hassan Nilforoushan, M.D., 25210 Grand River, Detroit 48240
J. Gil O'Rourke, M.D., 610 N. West Ave., Jackson 49202
Jose M. Parejo, M.D., 4342 W. Vernor Hwy., Detroit 48209



COUNTY SOCIETIES

Saginaw County Society Reaches High Schoolers

Saginaw County Medical Society members help area high school youth make their critical career decisions by sponsoring a number of activities for the Future Physicians Club of the local high school.

Most recent activity was a visit to the College of Human Medicine at Michigan State where the students gained a first-hand look at the study of medicine. The youngsters toured the medical school and veterinary medicine buildings, visited laboratories, saw new teaching techniques involving electronic equipment, sat in on an anatomy lecture and ate lunch with four medical school faculty members.

The club meets once a month at one of the area hospitals and the medical society arranges to have a doctor present at each meeting to explain a different area of medicine. Another major club activity is "A Day With a Doctor," planned each May, when a high school student spends an entire day following a doctor on his schedule.

Health Mobile A Hit in Hillsdale

A Health Mobile organized jointly by the Hillsdale County Medical Society and the Branch-Hillsdale Health Department made a five-day stand during February that attracted 500 county residents. A new Medical Manpower Recruitment Fund, established to pay transportation costs for prospective medical personnel who want to look over Hillsdale County as a place to settle and practice, already contains $1,400, according to Charles T. Vear, M.D., county society secretary.

Berrien Society, Auxiliary Cooperate on Project

The Woman's Auxiliary to the Berrien County Medical Society elected at its January meeting to purchase the film, "Marijuana," produced by Avanti Films, Los Angeles. The society provided a roster of physicians who would attend school showings for question and answer periods, as did local police departments and members of the sheriff's department. The film was previewed at a society meeting and was shown to all principals of junior and senior high schools in Berrien County before purchase. After the first three weeks it was shown in the county, it is estimated 7,000 students and adults had viewed the film.

On April 7 the Auxiliary donated the film for groups and further student studies to the Intermediate School District Film Library. The cost of the film, $350.00, was taken from Auxiliary dues. Full cooperation of the Auxiliary and Society has made this a very successful educational project for both.

Berrien Sponsors Radio Program

The Berrien County Medical Society sponsored a recent Community Forum radio program broadcast from Benton Harbor - St. Joseph dealing with the subject of "Coronary Care in Southwestern Michigan and the Outlook Today." The Chief of Staff and Chief of Medicine of the local Mercy Hospital were interviewed on the Sunday afternoon program, one of a series of Community Forum programs.

LCMS Members On Planning Council

Three Lenawee County Medical Society members are representing that organization on the Tri-County (Hillsdale-Lenawee-Jackson) Health Facilities Planning Council and have attended the council's meetings since January. They are Howard R. C. Eddy, M.D., Adrian, Richard D. Coak, Tecumseh, and Keith Whitehouse, M.D., Morenci.

By Patronizing

Our Advertisers

You Help Support

MICHIGAN MEDICINE

as easy as NTZ®

An easy solution to the problem of nasal symptoms of hay fever, colds and sinusitis

easy to prescribe: just write NTZ Nasal Spray.

easy to recommend: just say NTZ Nasal Spray.

easy to use: just one spray in each nostril, quickly followed by a second spray. Repeat q. 3 h. or q. 4 h. for temporary relief.

easy to dispense: the outer sleeve of the package is removable for easy application of prescription label.

easy to remember: as easy as NTZ.

But more than a simple vasoconstrictor:
NTZ Nasal Spray affords the well-known benefits of Neo-Synephrine®, 0.5 per cent, the more potent solution (adult strength) in a carefully balanced formula which includes:
Neo-Synephrine (brand of phenylephrine) HCl 0.5 per cent, decongestant
Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, antihistamine
Zephiran® (brand of benzalkonium, as chloride, refined) Cl 1:5000, wetting agent

Available: NTZ Nasal Spray in squeeze bottles of 20 ml.; NTZ Solution in bottles of 1 oz. with dropper.



prescribe NTZ® Nasal Spray
(contains Neo-Synephrine)

Winthrop Laboratories, New York, N. Y. 10016 Winthrop

Consumerism in American Economy

By C. T. HARDWICK, Ph.D.
MSMS CONSULTING ECONOMIST

The modern American political economy has been partly under the influence of slogans such as New Deal, Fair Deal, New Frontier, Great Society, and recently Consumerism.

This presentation is concerned with the implications of Consumerism in the health field dimension of contempory economics.

NATURE OF ISSUE

Historically, the central approach to the field of economics has been from the point of view of the producer, the market place and overall aggregate considerations. Nevertheless if we have producers or providers (supply side) there must be simultaneously another side of the market called consumers (demand side). Generally the consumers are the forgotten or neglected aspect of economic analysis. Also it must be noted that the American lives a dual life — both a producer and consumer. Usually greater efforts have put emphasis on education and preparation for the life of an effective producer while assuming consumption comes naturally. Times seem to be changing so that more attention is being given to the consumer interests.

In a partly free regulated economy (mixed), there are broadly three stages in the development of Consumerism. During the first stage, which is often called "laissez-faire" or "hands off and leave us alone," the producer is in power. At this initial stage, the phrase, "caveat emptor," or "let the buyer beware" is in vogue. The unorganized and nonvocal consumer has very little choice except to avoid and reject abusive and exploitive producers.

IN THE NEXT STAGE in a free enterprise economy, the neglected consumers tend to join forces by organizing into consumer groups to take over or fight the producers. For example, some associate in consumer credit unions for savings and loans to members. This stage is still underway and may be growing in America but has limitations as to interest and support in an affluent society.

The third stage arises from public pressures for government legislation and action in behalf of consumers. During the last three decades, the Federal Government has stepped up its activities in behalf of consumers especially through the Pure Food and Drug Acts and the Health, Education and Welfare programs such as Medicare and Medicaid. Activities in the U.S. in this stage are still growing — for example in social security and health fields.

Furthermore, modern crusaders like Ralph Nader have appointed themselves spokesmen for the consumers. Even in the health field, current books such as *The Healers, The American Health Scandal* and *Plot Against the Patient* make some serious accusations in behalf of the consumers of health services.

CONSUMERISM AND THE HEALTH FIELD

Although the practice is to use the words — patient and clientele — everybody on the demand side of the health market is in reality a consumer. Thus, he feels a kinship or unity as a member in consuming health services. Today, the consumers of health are better read and better informed about health matters. Because of mass media TV and popular magazines and newspapers, the consumer assumes a stance of sophistication which can and should not be ignored by the providers of health services. The modern consumer has developed a better taste for quality and at least a rough yardstick for measuring efficiency and effectiveness of service.

For example during a recent social gathering one of my friends was bragging about the thorough physical examination he went through with his internist at the office. It included blood tests, urine sample, test of blood pressure, extensive personal examination plus a cardiogram. He thought it was a good buy for forty dollars ($40). In contrast, another friend was quick to compare his annual examination the week before. It was all superficial and long on conversation and short on tests — no blood test, no urine sample, no cardiogram. Even at a lower cost of $30 he thought he was shortchanged and was very upset in the comparison with his friend. Although this



AUTHOR

Doctor Hardwick is economic consultant to the Michigan State Medical Society and associate dean, School of Business, University of Detroit.

example is an isolated situation, it is intended to convey from the layman's point of view the change in level of sophiscation of the ordinary consumer. His expectations are higher and he is quicker to criticize professional treatment.

WITH THE CHANGES in consumer attitudes toward health care, will come changes in consumer actions. There seem to be three general directions in which active consumers will move. First of all, individuals will tend to identify more and more as members of the group of health consumers. This single bond of identification will tend to put them in a position of opposition to the provider of health care. A second tendency will be to organize consumer groups to complain about costs and quality of health care. The third tendency will be to unite their efforts to create pressure through government representatives to take legal and political steps to control and regulate the providers of health care. All three steps can and probably will occur simultaneously. Furthermore, there is much evidence that all these steps are already underway and will undoubtedly increase their momentum in the months and years to come unless providers of health care take positive steps to satisfy consumers.

SUGGESTIONS FOR PHYSICIAN RESPONSE TO CONSUMERISM

The providers of health care should be particularly careful not to underestimate the real and potential power of consumerism. If and when the consumers of health services become better informed, they will demand more and more in quality of service; if and when consumers feel they have been neglected or abused, they will unite for the common action against the health establishment; if and when consumers recognize the strength of a united front, they will pressure the government representatives to take up their cause against the suppliers of health services.

The foregoing pre-positions offer both a threat and opportunity for physicians. In general it is popular to attack and blame physicians for high costs and poor service. In contrast, the physician has the opportunity to treat and handle not the consumers en masse but rather as individuals. Therefore, the physician must perform at a high professional level with every patient. The physician must be especially careful in his treatment of opinion molders such as teachers, lawyers, union leaders and government officials.

FURTHERMORE, THE PHYSICIAN must individually be well informed and also become influential in the socio-economic aspects of health care. Fees must be carefully related to quality medicine expected and delivered. Physicians can no longer assume that patients have blind faith in quality and changes. Consumers are ready, willing and even anxious to discuss the economics of health.

In addition to maintaining high level quality treatment of patients as well as explaining the consequent costs, the physician has to share the image of negativism in the social services field. Therefore, to fight that image, the physician individually and collectively through professional societies, must suggest constructive proposals to protect and assist the consumer of health care. Now is the time to develop new methods of delivering health services.

The issue of consumerism seems to revolve around the question of how to retain individual freedom in a society that drifts toward collective answers more often than ever before. The consumer of health care wants his freedom to choose or reject his physician as a personal choice. However, the consumer often feels weak and inadequate in dealing with the health care establishment especially in the area of costs and services. Thus, the consumer is tempted to enlist the help of government even when he knows that he will lose some freedom. In a like manner, the physician treasures his professional freedom in the practice of medicine but he also has drifted into accepting the influence of outsiders who curb his freedom under the guarantee of payment of fees.

THE POSSIBILITY STILL exists in America for consumers and physicians to join hands in the preservation of some freedoms in a society smart enough to work out procedures in the private sector to satisfy both parties. Wishful thinking will not make it so. Both the supply and demand sides of the health market place will have to accomodate each other. Furthermore, if practical and reasonable programs are not developed in the private sector we will continue to work toward government solutions.

With a new political administration in Washington which has stated its belief in private enterprise, the present seems to be a good time for some bold and creative proposals to present the American ideal of solving socio-economic questions in the private sector. Let us conclude by suggesting consumer and physician unite in a common cause and solve the problem themselves.

(Note: The MSMS Council in September approved recommendations to develop "Guidelines for Acceptance of Federal Funds by a Medical Society." These Guidelines were published in the December issue of **Michigan Medicine,** Page 1507.

The following article describes one of the on-going projects in California. The information is excerpted from the September, 1968 issue of **Group Practice.**

The subject of acceptance of medical funds by a medical society was one of the important subjects at the MSMS Second Annual Conference for Health Planning and Related Subjects at Western Michigan University, Kalamazoo, April 16-17. — Herbert Mehler, MSMS Government Agency Liaison)

Explains California County Medical Society Project Funded by OEO

In California, the Monterey County Medical Society obtained a grant from the OEO "to demonstrate the provision of comprehensive medical, surgical, hospital and other health services through private group practice."

Len Hughes Andrus, M.D., medical director for the Southern Monterey County Medical Group reports, "The grantee for the Rural Health Project is the Monterey County Medical Society, and the delegate agency is the Southern Monterey County Medical Group, a private group practice. The George L. Mee Memorial Hospital, a community, voluntary, nonprofit hospital, and the Pioneer Hacienda Nursing Home, a proprietary institution, are the collaborating agencies in the project. To the best of my knowledge, this is the only OEO project of its kind in the United States. The application was supported by the community action program of the OEO, the State and County Health Departments, the state director of the Anti-Poverty Program, and State and Federal legislators."

Doctor Andrus continues: "The Southern Monterey County Medical Group is a private group practice composed of nine full-time physicians. It consists of one internist, one surgeon, one anesthetist and six general practitioners, each with separate specialty interests. We have regular visiting consultants in orthopedics, dermatology, otolaryngology, radiology, urology, neurology and rehabilitative medicine. The physicians in our group have for many years been involved in community health activities, such as establishing a progressive school health program and participating with the high school and grammar school in health education programs. We have completed a tuberculin and coccidioidin skin testing survey, a coronary heart research program involving some 2,600 people and participated with Dr. Daniel Feldman of Stanford University in a rehabilitation pilot study. The individual doctors have been active in civic affairs such as city council, school boards, social and church organizations. The reason I mention these activities is to point out that the doctors of the group are all involved in the community in which they live. Two of the doctors live in Greenfield and the others reside ten miles south of King City.

"The Monterey County Hospital is located in Salinas, fifty miles north of King City. The indigent patients from the southern end of the county, thirty-five miles south of King City, must travel a distance of eighty-five miles each way. The usual plight of county hospital patients was theirs, i.e. waiting on hard benches for long hours, being seen by one resident one time and another resident next time, and after these long waits, having to come back the next day for laboratory tests or the results of the laboratory tests. The fragmented, inaccessible "patch work" emergency type of treatment with its lack of continuity existed in our area just as it does elsewhere under similar conditions.

"WE FIRST TRIED to solve the problem locally. We approached the county government with the approval of the Monterey County Medical Society with the idea of establishing a pilot study in our area. We knew we could take better care of the people and hoped we could do this on a competitive financial basis. Three out of five of the board of supervisors were in favor of this study, and we feel that monies would have been allocated for the study, had it not been for the passage of Medi-Cal, California's implementation of Title XIX of Public Law 89-97 (Medicare). Despite the enactment of this legislation, there were still a large number of people not covered for comprehensive medical care. We then learned of the activities of the Office of Economic Opportunity and applied for and received a grant of $626,913 to

(Continued on Page 542)

The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220

A·H·ROBINS

bring comprehensive health services to these people.

Doctor Andrus explains, "The tagret population consists of about eight hundred families and an undetermined number of nonresident migrant farm workers. In the past the families have either lacked medical care completely, have depended largely on the distant county hospital or have been treated on an emergency basis at our hospital and clinic. Monies available from various sources to pay for the care of our target population are identified and placed in a pool, the so-called 'pool concept.' Funds committed for the care of indigents from any other source are reimbursed to the project in cases where patients are eligible. For example, if a child is covered by the Crippled Children's Program and is a member of a needy family in our area, we bill the Crippled Children's Service and these funds are reimbursed to the grant. All physician and hospital care is billed on a fee-for-service basis and applied against the grant. A research component is also embodied in the project plan. All claims and costs will be analyzed to provide valuable data for others who may be planning health services for low income and indigent families.

"The project has already demonstrated that it is possible to provide comprehensive health services to the indigent through the setting of a private group practice clinic. The use of health and social welfare professionals in a group practice clinic and the feasibility of providing careers in the health fields to members of indigent families are also being demonstrated. This is one of the most thrilling aspects of our grant activities. The grant has also enabled us to add public health professionals to our group, which included for a brief period, a public health physician who later resigned for personal reasons.

Doctor Andrus reports, "The project activities are quite varied and are particularly exciting when compared with the conventional approach to meeting the medical needs of the community. The Community Health Coordinator, along with the help of the social worker, actually identifies the target population, i.e. the medically indigent. This task requires a certain type of "bird dog" who knows how to communicate with the people which, in our case, means speaking Spanish and physically scanning the whole south county.

"ANOTHER ASPECT of our activity contrary to all medical tradition is that of soliciting patients and trying to get them to come in for checkups or for evaluation of their complaints. Most of these patients have seen a physician only when they are hurting, sick or injured. Preventive and medical health check-ups are completely unknown to them. The entire previous medical contact has been on somewhat of a battalion aid-station type of relationship, i.e. in the waiting room and corridors of our county hospitals or as emergency patients in our private hospital and clinic.

"We are attempting to recognize disease in these people and to keep accurate statistics on them, as well as on our other private patients. With our IBM computer, data on every contact is coded and the disease classified according to ICDA code. We are attempting to discover disease and treat it, and to maintain surveillance over the conditions uncovered. We are trying to stress health education and the prevention of disease. We are becoming more active in family planning, which has heretofore been a sensitive area of involvement.

"Our method of delivering medical care has therefore added to the dimension of conventional care of private patients by incorporating these other additional services and activities, including the solicitation of patients, the transportation of patients, home health care activities and health education. My use of the word 'solicitation' is used deliberately, in a most constructive sense. Our three busses keep busy bouncing over the area bringing in patients who otherwise would probably never seek or receive medical care. This is one reason why, in the past, the only time we saw some of these patients was when they were acutely ill."

Doctor Andrus points out, "In the Southern Monterey County Medical Group our approach toward meeting the medical needs of our area has been that of attempting to solve the problem on a local basis; yet its potential for widespread application is enormous.

"BRIEFLY STATED, our philosophy is that private medicine should recognize the medical needs of the community and attempt to solve them in an aggressive and creative manner. When it is impossible, for a variety of reasons, to meet the needs through the historic methods of private practice, we should not be reluctant to turn to the government for assistance, but on the condition that we maintain the reins of medical guidance and direction. If we do not, the private sector of medicine will be submerged by the tides of, and demands for, social change. Some of the people who are steering the course for change reflect a variety of the ideas of the Public Health Service, public health departments, medical schools, universities and government. Not excluded are the concepts of segments of professionals and the lay public. The opinions of the private practicing physician are not adequately represented, yet he must become aggressively involved if his voice is to be heard.

"Our brief experience has revealed to us that medicine oriented to the diagnosis and treatment of symptoms which is fragmented, inaccessible and lacking in continuity, is not confined to poor people, but to the private patient as well. It has further revealed that we must develop practical and workable innovations in medical service. In a

rural area like Southern Monterey County we are trying to meet the medical needs of our community and are receiving the satisfaction and enjoyment, as well as experiencing the excitement, which new horizons offer. Physicians in private practice, medical educators, and professionals in government agencies can, we believe, not only gain from the experiences we have had, but can apply and enlarge upon them, bringing new services and new manpower to areas and segments of the population where health service voids exist."

STATE'S BUSINESSMEN WOULD CURTAIL SUPREME COURT

A majority of Michigan's independent business owners polled by the National Federation of Independent Business believe that the U.S. Supreme Court should not be so supreme. Fifty-two percent of the state's businessmen polled endorsed a proposed Constitutional amendment which would give Congress veto power over the Court.

INTERNATIONAL 'BRAIN DRAIN' OF DOCTORS BEING STUDIED

A study of the International Brain Drain of Physicians is being undertaken at the University of Michigan by Irene H. Butter, Ph.D. Her two-part study was begun June 1, 1967 and is scheduled to be concluded May 30, 1970.

Doctor Butter is attempting to 1) survey 130 countries around the world to measure the migration of medical doctors, most specifically medical graduates, to and from the countries, and 2) to analyze AMA data on foreign medical graduates in the U.S.

In the first part of her study Doctor Butter would like to learn where physicians go, to and from any country, and also to compile data on the supply and distribution of doctors in each country, their earnings and the cost and financing of medical education in each country.

In the second part of the study, Doctor Butter is focusing her analysis on learning to what degree foreign medical graduates help alleviate the doctor shortage in the U.S., geographically and by specialty.

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road — Conducted by Sisters of Mercy — Ann Arbor, Michigan

Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

Lyle M. Allis, M.D.
Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.*
Sydney Joseph, M.D.
Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Richard D. Watkins, M.D.
Stephen C. Mason, M.D.
Philip M. Margolis, M.D.
Hubert Miller, M.D.

* 1904 - 1967

MSMS Members In the News

GERRIT KEMME, M.D., ZEELAND,
is new president of the West Michigan Academy of General Practice. Other new officers recently elected are J. Jay Post, M.D., Allendale, president-elect; John A. Voss, M.D., Grand Rapids, vice president, and G. Edward Braunschneider, M.D., Grand Rapids, secretary-treasurer. All are MSMS members.

BRUCE L. DANTO, M.D., DETROIT,
director of the Suicide Prevention Center of Detroit Psychiatric Institute, has been appointed consultant editor to the Bulletin of Suicideology.

FREDERICK J. MARGOLIS, M.D., KALAMAZOO,
pediatrician and member of the Wayne State University School of Medicine faculty, is developer of a six-minute, color-sound cartoon, "Sniffy Escapes Poisoning," which was the main feature of the state-wide Poison Prevention Program of the Michigan State Pharmaceutical Association during Poison Prevention Week. Local MSPA societies purchased 22 copies of the film to be shown by television stations during prime child viewing time.

ARTHUR C. CURTIS, M.D., ANN ARBOR,
has been elected an honorary member of the prestigious New York Dermatological Society by unanimous vote and has been invited to a scientific program marking the society's 100th anniversary this month. Doctor Curtis is professor emeritus of dermatology at the University of Michigan.

JOHN F. COTANT, M.D., DETROIT,
was recently elected president of the Detroit Board of Health. Doctor Cotant, chief surgeon at Providence Hospital, succeeds James J. McClendon, M.D., who has been reappointed to a four-year term as member of the board.

C. MARK VASU, M.D., GRAND RAPIDS,
an internist, is new president of the Kent County Unit of the Michigan Heart Association. Doctor Vasu, who replaces outgoing president Vincent J. Turcotte, M.D., has served on the local Heart Board five years and is past chairman of the Heart Association's state Cardiopulmonary Resuscitation Program committee.

ROBERT TOTEFF, M.D., SAGINAW,
was one of 12 persons chosen for the new Saginaw Catholic Board of Education.

IRWIN S. FINKELSTEIN, M.D., DETROIT,
is new director of Psychiatric Education and Research at Pontiac State Hospital and has joined the faculty of Michigan State University's College of Human Medicine as clinical assistant professor of psychiatry. He was co-director of In-Patient Services at Detroit Psychiatric Institute and Instructor of Psychiatry at Wayne State University School of Medicine.

ROGER B. NELSON, M.D., ANN ARBOR,
has been appointed chairman of the Forum Planning Committee for the Medical Staff-Trustee-Administrator Forum set May 14-16 at Boyne Mountain Lodge and to be sponsored by the Michigan Hospital Association.

DeVERE R. BOYD, M.D., MUSKEGON,
is chairman of the local Mental Retardation Citizens Committee which was instrumental in locating the new Regional Mental Retardation Center at Muskegon. The 254-bed center, dedicated March 28, will serve Lake, Mason, Muskegon, Newaygo, Oceana and Ottawa Counties.

WILLIAM LeFEVRE, M.D., MUSKEGON,
received the Meritorious Award of the Michigan Diabetes Association at a recent meeting of the Muskegon County chapter, MDA. Presenting the award was Fred W. Whitehouse, M.D., Detroit, MDA president. Both doctors are MSMS members. Doctor LeFevre, notes a recent issue of the *Michigan Diabetes Newsletter,* is "a Michigan doctor renowned for his devotion to his diabetic patients."

JOHN GALL, M.D., ANN ARBOR,
University of Michigan geneticist and pediatrician, and a MSMS member, accompanied the U of M Dental School's March expedition to Upper Egypt, where they took cephalograms and gave dental care to Nubian children. Doctor Gall's contribution consisted in making physical examinations of the children and taking hand and fingerprints for future genetic studies. The hand and fingerprints are the first to be taken of the Nubian children and it is hoped they will reveal certain genetic relationships with other ethnic groups.

JAMES S. FEURIG, M.D., EAST LANSING,
was the consultant for a question on parental consent for medical treatment of athletes discussed in the Medicine in Sports Newsletter No. 2 of the Rystan corporation of Bloomfield, N.J.

Two good reasons to specify LEDERCILLIN® VK

Potassium Phenoxymethyl Penicillin

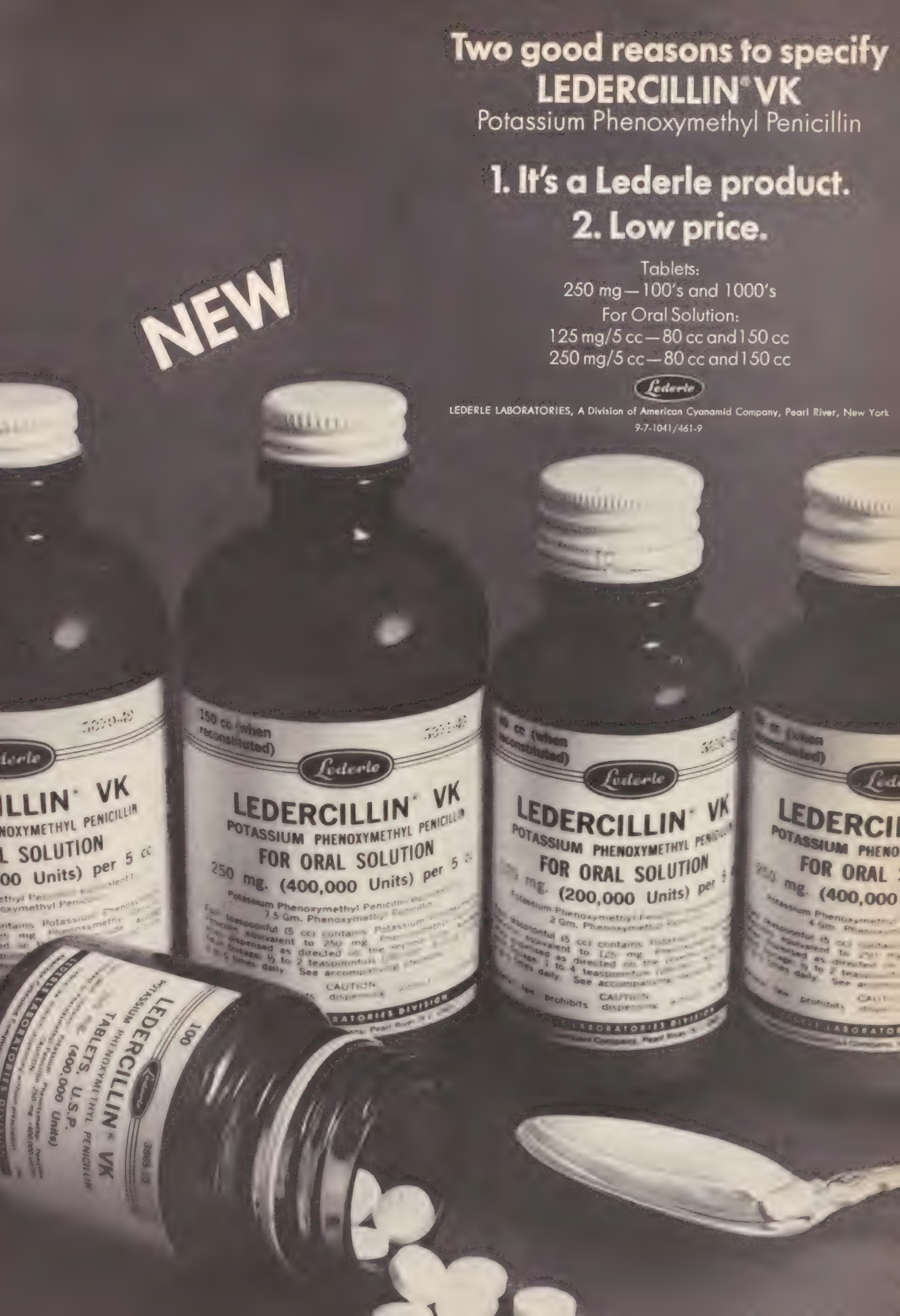
1. It's a Lederle product.
2. Low price.

Tablets:
250 mg—100's and 1000's
For Oral Solution:
125 mg/5 cc—80 cc and 150 cc
250 mg/5 cc—80 cc and 150 cc

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York
9-7-1041/461-9

NEW





Scientific Articles Printed to Date

Each month *Michigan Medicine* prints selected outstanding scientific articles. To date, the following papers (with month, page number and author following) have been published:

JANUARY

Page 31, *"Lower Lung Field Tuberculosis,"* by Ma. Zenaida Fernandez, M.D., Zamboanga City, The Philippines, and Edward G. Nedwicki, M.D., Allen Park.

Page 36, *"Use of Cholesterol Kits,"* by Kenneth R. Wilcox, M.D., (Reprint from New England Journal of Medicine, Vol. 279, No. 18).

Page 37, *"Mammography and Xeroradiography,"* by John N. Wolfe, M.D., Detroit.

Page 39, *"Early Management of Facial Nerve Trauma,"* by Roger Boles, M.D., Ann Arbor.

Page 45, *"Treatment of Hypercalcemia,"* by Joseph J. Weiss, M.D., and Jose Yanez, M.D., both of Eloise.

Page 49, *"More Drugs Mean More Problems in Managing Diabetes Mellitus,"* by John B. Bryan, M.D., F.A.C.P., Royal Oak.

FEBRUARY

Page 119, *"The Future of Private Practice: Salvation at the Grassroots;"* by Lewis A. Miller, Stamford, Conn.

Page 131, *"Mouse Toxicity of Triple Vaccine (DTP) Mixed with Poliomyelitis Vaccine,"* R. Y. Gottshall, G. R. Anderson, E. A. Nelson and K. R. Wilcox, M.D., all of Lansing.

Page 135, *"Massive Intra-articular Injection of Methylprednisolone without Harmful Side Effect,"* by J. C. Breneman, M.D., Galesburg.

MARCH

Page 209, *"Myocardial Infarction During Hyperthyroidism,"* by Robert C. Douglass, M.D., Southfield; Myer Teitelbaum, M.D., Detroit, and Gerald J. Aben, M.D., Southfield.

Page 213, *"Trichophyton Violaceum,"* by James D. Stroud, M.D.; Jules Altman, M.D., and Coleman Mopper, M.D., all of Detroit.

Page 215, *"Psychiatric Referral of a Pediatric Patient,"* by Joan R. Chodorkoff, Ph.D., and Bernard Chodorkoff, M.D., Ph.D., both of Detroit.

Page 217, *"Development of a Program of Laryngoscopy, Therapeutic Bronchoscopy and Endobronchial Blocking Techniques: A Progress Report,"* by Martin L. Norton, M.D., F.A.C.C.P., Detroit.

Page 220, *"Accidental Poisoning, Where Do We Go From Here?"* by George M. Lowrey, M.D.

Page 221, *"Diabetes and Pregnancy — Preliminary Report,"* by Nancy T. Caputo, M.D., and Agna N. Pineda, M.D., both of Detroit.

Page 223, *"The Electrophoresis of Lipoproteins,"* by John G. Batsakis, M.D., and Martha M. Thiessen, B.S. (ASCP), both of Ann Arbor.

APRIL

Page 341, *"Suprapubic Cystostomy In Gynecologic Surgery,"* by Morton R. Lazar, M.D., F.A.C.S., F.A.C.O.G., and Eugene A. Snider, M.D., both of Detroit.

Page 345, *"Rhabdomyosarcoma: Report of 20 Cases,"* by Lawrence S. Bizer, M.D., Detroit.

Page 349, *"Psychiatric Referrals In A General Hospital,"* by Wiecher H. Van

IN MEMORIAM

James B. Beatty, M.D.
Russellville, Ala.

James Bruce Beatty, M.D., former Coldwater surgeon and medical director of Coldwater's Maple Lawn hospital, died Feb. 26 in Russellville, Ala., where he had recently moved.

Doctor Beatty, 36, was a graduate of the University of Tennessee Medical School and a former treasurer of the Branch County Medical Society. He specialized in surgery and was associated with the Russellville Clinic at the time of his death.

Harry L. Buller, M.D.
Manchester, Conn.

Harry Lancaster Buller, M.D., retired Detroit doctor, died March 9 in Manchester, Conn., where he had been living.

Doctor Buller, who was 76, was graduated from the Detroit College of Medicine and practiced approximately 46 years in Detroit. He was a former member of the Grace Hospital staff and a life member of the Wayne County Medical Association.

Frederick E. Dodds, M.D.
Flint

Frederick Earl Dodds, M.D., a Flint physician for 40 years, died Feb. 27 at the age of 79.

A graduate of Wayne State University Medical School, Doctor Dodds was honored in 1966 by the Wayne Medical School alumni association for 50 years' service to the medical profession.

Doctor Dodds was a general practitioner and was on the staff at Hurley, St. Joseph and McLaren General hospitals in Flint. His first practice was in Lapeer County and Saginaw.

Charles Ornstein, M.D.
Southfield

Charles Ornstein, M.D., Southfield physician, died March 20 at the age of 63.

Doctor Ornstein, a general practitioner, was on the staff of St. John Hospital in Detroit and was a graduate of Wayne State University Medical School. He was a member of the Maimonides Medical Society.

William F. Peterson, M.D.
Muskegon

William Francis Peterson, M.D., Muskegon general practitioner, died March 1 at the age of 45.

Doctor Peterson was a graduate of the University of Buffalo School of Medicine and was also an ordained minister. He was a member of the New York State Medical Society, the Christian Medical Society, the American Academy of General Practice and the Michigan Association of the Professions.

He was affiliated with Mercy, Hackley and North Shore hospitals in Muskegon.

Leland P. Shipp, M.D.
Battle Creek

Leland Parmater Shipp, M.D., Battle Creek physician for 47 years, died March 2 at the age of 64.

Doctor Shipp, who was graduated from University of Michigan School of Medicine and was a specialist in internal medicine, was twice awarded the Battle Creek *Enquirer and News* "George Award" for significant contributions to the community. The first award was for fostering and conducting a series of public medical forums in 1957, the second for inaugurating, organizing and directing the Health Fair which was a feature of Battle Creek's Centennial program.

He was a diplomate of the American Board of Internal Medicine, a fellow of the American College of Physicians and the American College of Cardiology, past president of the Calhoun County Medical Society and a past president of the medical staffs of Leila and Community hospitals in Battle Creek.

Doctor Shipp was medical consultant for 16 years to the VA Hospital at Fort Custer and cardiology consultant for Albion Community Hospital, Hayes-Green-Beach Hospital in Charlotte, LaGrange Community Hospital, Oaklawn Hospital in Marshall, Pennock Hospital in Hastings and Sturgis Memorial Hospital.

Doctor Shipp was also an active supporter of community sports activities and an avid outdoorsman.

SCIENTIFIC ARTICLES, CONTINUED

Houten, M.D., Ann Arbor.

Page 353 ,*"The Sinai Hospital Low Vision Clinic,"* by Morris J. Mintz, M.D., Ernest M. Gaynes, O.D., and Arnold H. Gordon, O.D., all of Detroit.

Page 357, *"The Physician and Differential Diagnosis of Communicative Disorders in Children,"* by Gerald S. Light, M.D., and William Wolski, Ph.D., both of Flint.

Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

PSYCHIATRIC RESIDENCIES: Approved three-year community oriented dynamic program in Metropolitan Detroit area. University association. Teaching staff of Board men, psychoanalysts, professors, outstanding visiting lecturers. Active research. Modern physical plant. Salary $10,666; $11,185; $12,132. Five year career program $12,155 to $21,942. Liberal Civil Service benefits. Write: Director of Education and Research, Northville State Hospital, Northville, Michigan 48167.

WANTED: Physician to work as a partner in a thriving community in southern Michigan. Present hospital is in the process of being enlarged. The medical offices are in the hospital building. Exceptional opportunity for the right man interested in general practice. He should be competent to do general surgery. A Locum tenens is greatly needed during the summer months to relieve the present physician after a long hard winter's work. Contact: B. H. Growt, M.D., Medical Center, Addison, Michigan 49220.

MEDICAL DIRECTOR: For well established Health Department in Allegan County, Allegan, Michigan, serving 60,000 population. Requires: M.D. Salary commensurate with experience. Benefits: Paid vacation, holidays, sick leave and retirement program. Please write: John Pahl, Acting Director, Allegan County Health Department, Allegan, Michigan 49010.

OB-GYN Specialist, highly qualified, experienced, British, Double Board certified, American Board eligible with considerable independent clinical operative teaching and research experience seeks suitable high calibre practice. Either solo, associate or partnership – group practice may be considered. Married with three children. Good schools, living conditions and freedom to practice good medicine essential. Michigan license. Available in June. Write Box 3, 120 West Saginaw, East Lansing, MI 48823, or phone (313) 334-0333.

Michigan licensed physician wants part time work evenings. Weekends also considered. (Wayne, Oakland, Macomb County area). Write Box #5, 120 West Saginaw Street, East Lansing, MI 48823.

G.P. Partner needed for growing practice in lower peninsula town of 2,000 population. Salary first year $20,000 and 50/50 partnership second year. Hunting, fishing, swimming, boating, skiing, canoeing, golfing nearby. Easy access to large population centers on new expressway. Reply Box 1, 120 West Saginaw Street, East Lansing, Michigan 48823.

PHYSICIANS WANTED: Internist, General Practitioner, Ob-Gyn, Orthopedist needed for additional staff to established 15-man medical group in Detroit. Excellent professional relationships. Guarantee of $25,000 minimum, plus bonuses. Reply Box #2, 120 West Saginaw Street, East Lansing, Michigan 48823.

ALPENA, MICHIGAN–Middle aged Generalist with General, Gynecological and Traumatic Surgical practice retiring due to failing health. $40M to $60M gross annually prior to restriction of activities. Excellent opportunity for a Generalist with two years Residency in General Surgery or Gynecology. Modern office building one block from center of city, complete with office equipment and clinical lab., excellent office staff; office and in-hospital surgical instruments. 200 bed modern Accredited Hospital. Complete records for 29 years. Will rent, lease, or sell building and equipment; will introduce and help in obtaining staff appointment. Will assist in financing. This is not an opportunity for a Generalist without special training as outlined above. Contact: John W. Bunting, M.D., 110 N. First St., Alpena, Michigan.

GP wanted for association with a surgeon and a well established general practitioner at Standish, Mich. New and progressive 80 bed hospital with CCU unit. Office space available. Financial arrangements open to discussion. Please call collect, Malcolm K. Dolbee, M.D., Area code 517-846-6122.

FOR RENT: Medical suite modern air conditioned, part of Medical-Dental building in Dearborn. Excellent location. Call or write: Francis A. Lutone, D.D.S., 23401 Ford Road, Dearborn, Michigan 48128. Phone (313) LOgan 1-3367.

INTERNIST – Board Certified or eligible. 269-bed General Medical and Surgical Hospital in Michigan's Upper Peninsula. Licensure any state, salary dependent upon background and qualifications. Excellent benefits for retirement, vacations, sick leave, and professional improvements. Non-discrimination in employment. Contact: Chief of Staff, VA Hospital, Iron Mountain, Michigan 49801.

Medical Technologists: Also Histotechnologists ASCP registered or eligible. Modern clinical laboratory. Starting salary $635 per month with increases to $760 per month. Excellent fringe benefits include tuition reimbursement, paid vacations, insurance and holidays. Write or call collect (487-6111 area 517). Edward W. Sparrow Hospital, Personnel Department, 1215 E. Michigan Avenue, Lansing, Michigan 48912.

UROLOGIST needed to join established multi-specialty group in Detroit. Excellent professional relationships. Guarantee $25,000 minimum, plus bonuses. Reply: Box 4, 120 W. Saginaw Street, East Lansing, Michigan 48823.

Ferris State College is seeking an additional physician to complete the staff of the Student Health Center. Attractive salary, fringe benefits, pleasant location, excellent facilities and working conditions. Please contact Roy A. Davis, M.D. (616) 796-8635 or write c/o Ferris State College, Big Rapids, Michigan 49307.

MEDICAL DIRECTOR – Single County Health Department; with 40 employees, population 165,000. VD, TB, and general health programs. Good relations with local physicians. Excellent recreational and school facilities. If under age 50 require MD or DO degree and obtain MPH within 3 years with state assistance. Over age 50, require 9 weeks of special courses over 3 years in lieu of MPH. Salary range $23,000 to $27,500. Starting rate depends on qualifications and experience. Usual fringe benefits. Send application and resume to Acting Director, James V. Wells, Muskegon County Health Department, County Building, Muskegon, Michigan 49440.

Index to Advertisers

They Help Make Michigan Medicine Possible

Abbott 462, 463, 464
Brighton Hospital 524
Bristol Laboratories 509
Brown Pharmaceuticals 524
Burroughs-Wellcome 534
Campbell Soup Co. 497
Classified Advertising 548
Geigy Pharmaceuticals 502, 503, 504
Harcliffe Laboratories 515
Hynson, Westcott & Dunnings, Inc. .....Cover II
Ingram, G. A. Co. 464, 508
Lederle Laboratories 456, 506, 517, 523, 545
Lilly, Eli & Co. 468
Loma Linda Foods 507
Mallard, Inc. 495, 496
McNeil, Laboratories Inc. 510
Medical Protective 508
Mercywood Hospital 543
Michigan Medical Service 458
National Drug Co. 517
Parke-Davis & Co. 512
Plainwell Sanitarium 516
Poythress, Wm. P. & Co. 461
Purdue Frederick 528, 529, 530
Professional Management 549
Robins, A. H. & Co. 541
Roche Laboratories .....531, Cover IV
Sandoz 500
Searle, G. D. & Co. 498, 499
Stratton, Ben P. .....Cover III
Wallace 528, 529, 530
Westamerica Securities 527
Winthrop Labs 537

Increase Practice Control Through MANAGEMENT By

Modern office and financial management offers realistic methods toward achievement of personal life goals. A logical outcome of PM's services is the attainment of your objectives.

OBJECTIVES

- More Time for Patient
- More Time for Leisure
- Better Collection Control
- Better Cost Control
- Assistance With Financial Planning
- Identify Business Problems
- Seek Best Solutions to Problems

PROFESSIONAL MANAGEMENT
Black and Skaggs Associates, Inc.
Battle Creek, Michigan

Serving Michigan Physicians

Offices in these cities
Ann Arbor - Battle Creek - Berkley - Detroit - Flint
Grand Rapids - Lansing - Muskegon - Saginaw - Traverse City

NOTES & QUOTES

BY HERB AUER, EXECUTIVE EDITOR

"During the first half of 1968, Americans bought some 40 million fewer cigarettes each day than in 1967," reports the American Cancer Society in its publication *1969 Cancer Facts and Figures.*

The Society estimates that 21 million Americans have quit smoking cigarettes, including some 100,000 physicians — about half of all the physicians who formerly smoked.

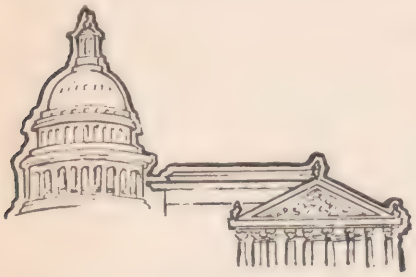
Grim footnote: Even so, about 59,000 Americans will die of lung cancer this year.

* * *

"Will the doctors ever march on Washington?"

That provocative question was raised in an address to the Medical Association of Georgia's annual meeting by Senator Paul Fannin, Republican of Arizona.

He then went on to answer the question: "I certainly hope not; but at the same time doctors do



have a responsibility to voice your opinions and your views in Washington."

Senator Fannin told the doctors, "You have the opportunity to help form opinion; and the machinery through your PAC organizations."

He added, "The hour is late and the time is short. Speak up. Work hard. Think soundly."

* * *

In 1968, more than 165,000 persons complained to the Post Office Department about the smut and pornography which was mailed into their homes. Congressman Marvin Esch, Ann Arbor, explains, "An individual under Public Law 90-206 can require a mailer of offensive material to remove his name from the list and cease such mailings in the future. If you receive an offensive mailing, you should take the mailing, including the envelope, to the local Post Office where the Postmaster will gladly furnish you with a legal complaint form. Your name and those of your children under 18 must be removed from the list within 30 days or the mailer is liable for federal prosecution."

* * *

Our reactions to what we hear affect our receptivity of the subject matter. An expert lexicographer, Wilfred Funk, has selected the 10 most expressive words in the English language.

1. The most bitter word is "alone"
2. The most reverent — "mother"
3. The most tragic — "death"
4. The most beautiful — "love"
5. The most cruel — "revenge"
6. The most peaceful — "tranquil"
7. The saddest — "forgotten"
8. The warmest — "friendship"
9. The coldest — "no"
10. The one bringing most comfort — "faith"

This article is reprinted from a recent issue of **The Professional Medical Assistant** journal.

* * *

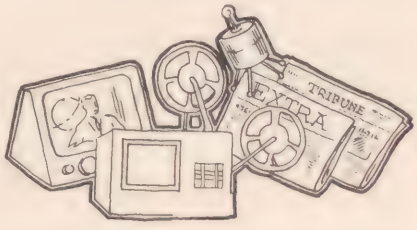
A Little Boy's Essay on Anatomy:

Your head is kind of round and hard and your brains is in it and your hair is on it. Your face is the front of your head where you eat and make faces. Your neck is what keeps your head out of your collar. It's hard to keep clean. Your stummick is something that if you don't eat often enough it hurts and spinach don't help none. Your spine is a long bone in your back that keeps you from folding up. Your back is always behind you, no matter how quick you turn around. Your arms you got to pitch with and so you can reach the butter. Your fingers stick out of your hands. Your legs get you to first base. Your feet are what you run on, and your toes are what always gets stubbed. And that's all there is of you 'cept what's inside, and I ain't seen that. (Source: Unknown)

* * *

Many predictions are made by John Walker Powell in an article in *Adult Leadership* about systems and society. One of the provocative paragraphs in the aricle, entitled "Communication, Technology and Education" follows:

"The library of the future will be not a repository for books but an electronic data center, giving you access to all types of information—print, audio, pictures, voice tapes and computer access. The



school is beginning to be replaced, in current New Town planning, by decentralized learning spaces that may be in homes, apartment buildings, stores, public buildings, libraries, and—for all I know—bars; wherever is convenient for the learners—of all ages."

* * *

A program of postgraduate medical education tailored to the needs and desires of the physicians, would be desirable and helpful. So says 96% of the Mississippi physicians recently surveyed there in a statewide study. Only 4% said that a PG program is neither necessary nor desirable. Seventy-seven percent said they would favor a combination of on-campus institutes with intensified home study.

* * *

Overheard in a doctor's office:

"I've done all I can to get your weight down. Now, I suggest you learn to be jolly."

YOU ARE ENTITLED

TO COMPLETE SERVICE CONCERNING ANY OF THE INSURANCE PLANS SPONSORED AND ENDORSED BY THE

MICHIGAN STATE MEDICAL SOCIETY

Group Term Life

Group Long Term Disability

Professional Overhead Expense

Accidental Death And Dismemberment

Accident & Sickness Plan For Your Employees

The Ben P. Stratton Agency, Inc. also provides complete insurance service for Professional Corporations, Partnerships, or Individuals. Your inquiries concerning valuable fringe benefits are invited. Professional Liability insurance is also available.

Call collect, or write —

BEN P. STRATTON AGENCY, INC.

MSMS Insurance Administrators

P. O. Box 547, Lansing, Michigan 48903

Telephone: (517) 484-2578

Return Postage Guaranteed

MICHIGAN STATE MEDICAL SOCIETY
120 W. Saginaw
East Lansing, Michigan 48823

MJ
NATL LIBR OF MEDICINE
8600 WISCONSIN AVE
BETHESDA 14 MD 20014





from the discord of anxiety... **to emotional harmony**

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)
5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:
Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

MI 225

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

MAY, 1969 • VOLUME 68 • NUMBER 10

NATIONAL LIBRARY OF MEDICINE
RECD. JUN 23 1969
INDEX
INPUT

PHYSICIANS, OTHERS URGED TO OPPOSE OSTEOPATHIC COLLEGE BILLS HB 2196, SB 70

MSMS, in Opposing Osteopathic College Bills, Stresses Economy, Logic of Other Approaches

Michigan physicians, labor leaders, educators, economists, and others have increased their efforts to influence Michigan legislators not to commit state tax dollars toward the establishment of an osteopathic college.

MSMS officials have explained proposed bills and alternatives to every member and have urged action programs.

Acting in the interest of the public, MSMS officials are explaining a positive position:

"For Michigan residents to get the 'most bang for the buck,' the Michigan legislature should endorse the proposal that the three medical schools offer students the option of an MD or DO degree, rather than establish a Michigan College of Osteopathic Medicine."

That position recognizes the deep concern about the shortage of state funds for colleges in Michigan.

MICHIGAN CAN GET more physicians quicker and more economically, points out MSMS and others, by supplying funds to enlarge the entering classes at the three present medical schools rather than establishing new ones. This position has been advocated for many years by MSMS.

The expansion of current medical schools as the best approach to medical manpower shortages is recommended by HEW Secretary Robert H. Finch, the American Association of Medical Colleges and many others.

For every additional dollar given to one of the three Michigan medical schools, Michigan can obtain not only more high-quality physicians but also more of the needed allied health professionals to serve the total medical needs of the state.

THE PROPOSALS TO establish a state-supported osteopathic college with its own board of control is very costly compared with an optional degree approach at the three existing medical schools. All three universities have indicated officially to the State Board of Education that students could be permitted to "opt" to obtain either an MD or DO degree. As an alternative to present bills, MSMS does not oppose medical schools offering optional degrees to osteopathic students.

The establishment in Michigan of a tax-supported osteopathic college is unwise. No new osteopathic school has been established in the nation in the past 50 years. There are fewer osteopathic schools and osteopathic graduates now than 13 years ago. There are five small osteopathic colleges in the nation remaining.

ESTIMATES DEVELOPED by legislative aides and others place the costs for an adequate Michigan osteopathic school between $60,000,000 and $100,000,000 during the next seven years, to graduate an annual class of 64 DOs.

Michigan residents can get the "most bang for the buck" if the tight funds available for education are not siphoned off for an osteopathic school, but are appropriated to the medical schools at the University of Michigan, Wayne State University and Michigan State University.

"NOT THE TIME FOR OSTEOPATHIC SCHOOL"

One of the leading Michigan daily papers has discussed the question of an osteopathic college on its editorial page and following are some short quotes:

"There is every good reason for the state to proceed slowly with plans to support a college of osteopathic medicine."

". . . an osteopathic college with state support and university control is a maverick institution supporting itself on dribbles of federal aid, citizen contributions, and money from the osteopaths themselves."

"The state just isn't ready, in our estimation, to endow a small and controversial 'branch' of medicine with a college of its own."

These comments are from the *Ann Arbor News*.

MSMS Recommendations to Expand Existing 3 Schools Concur with AAMC-AMA Stand

The recommendation that the three existing medical schools in Michigan be expanded is consistent with the joint statement by the Association of American Medical Colleges and the American Medical Association.

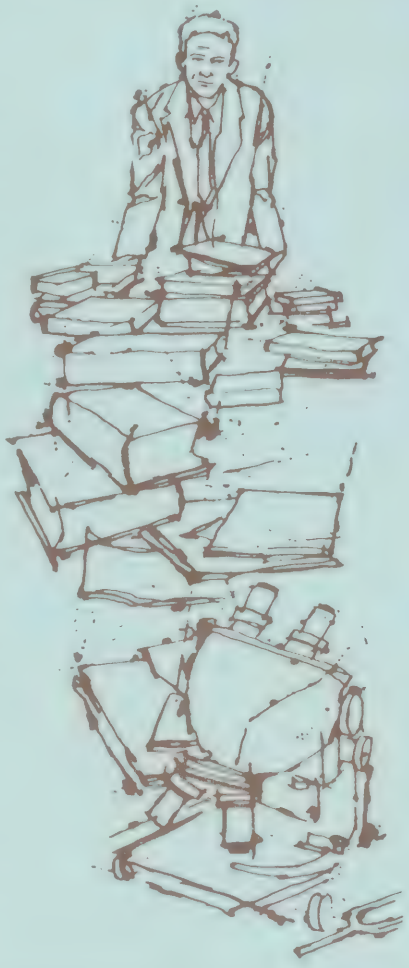
The two organizations issued both immediate and long range steps, declaring that "To meet national expectations for health services, the enrollment of our nation's medical schools must be substantially increased."

The first immediate step suggested is:

"To increase the enrollment of existing medical schools. Considering the time required to create new schools and to provide a student with a medical education, there is no alternative to this step in meeting our present emergency."

The joint statement recognizes that "A longer-range approach to the need for physicians is the development of new medical schools," although cautioning that "this approach will not solve our immediate, urgent need for more physicians."

While the Michigan State Medical Society has been actively involved for many years in urging expansion of Wayne and the University of Michigan and in the creation and growth of MSU, the AMA has been active on the national level. Since 1947, 16 new schools have opened to train doctors of medicine; and by 1971, the present total of 94 will jump by 10 more to a total of 104. An estimated 30 other schools have plans on the boards to train doctors of medicine.



There are five osteopathic schools, with no new ones in operation in the past 50 years. The osteopathic schools, which never graduated as high as 7% of the total number of physicians in the USA graduating in any single year has gradually produced a lesser number until today it graduates only 5%. Missouri, Ohio, Pennsylvania and Michigan have about 45% of the total osteopaths in the world, with many states and nations having no osteopaths or only a few.

HEW SECRETARY SAYS SOLUTION IS TO ENLARGE PRESENT SCHOOLS

Following is one of the first statements made about medical schools by Robert H. Finch, the new secretary of Health Education and Welfare, as quoted by the United Press International; May 25, 1969.

"We are vitally concerned about the existing facilities and their efforts to increase their graduating classes. I am concerned as are the medical profession and the medical schools themselves, that we are averaging fewer than a hundred graduates out of each of our major medical schools. The need is to enlarge the number of physicians being trained by the nation's present medical schools. The need is immediate."

HEW has estimated a current shortage of 52,000 physicians in the nation.

"FOOLISH FOR STATE TO SUBSIDIZE TWO MEDICAL APPROACHES"

"If the scientific basis for all medicine is the same, it is foolish for the state to subsidize two separate professions," MSMS Council Chairman Ross V. Taylor, M.D., was quoted as saying in a news article in the *Detroit News*, November 8.

The *Detroit News* writer was asking Doctor Taylor about the MSMS endorsement last year that the three medical schools offer optional degrees.

Doctor Taylor explained, "This plan will be controversial for some time, but we feel it is in the best interests of the people of the state."

The optional degree approach, Doctor Taylor said, is endorsed "because of our deep concern about the serious shortage of physicians and paramedical personnel in Michigan."

Michigan AFL-CIO Chief Testifies Againist Legislation Supporting Do School Now

The state legislature should not begin any fourth medical school now until the three present medical schools "have no longer any possibility of expansion."

So declared August Scholle, president of the Michigan AFL-CIO, in testimony before the Michigan House of Representatives Appropriations Committee. Voicing the concern of "protecting the pocketbooks of the people that I represent," Mr. Scholle asked the legislators "Where are you going to get the money . . . Are you going to increase taxes somewhere along the line?"

Mr. Scholle pointed to the financial crisis facing education on both the local and state level and also endorsed proposals by the three medical schools to provide for an osteopathic degree. He closed his testimony by saying, "I am very, very vigorously opposed to the creation of an osteopathic college – something that we don't need now."

After the present schools reach their maximums, Mr. Scholle said he would be the first to lead efforts for a fourth school, "and I don't care whether it is an MD or a DO school," he added.

The legislators were told at the hearing March 26 on HB 2196 by Mr. Scholle that the three present schools should be expanded as the wisest use of taxpayer money. He reported that "All three medical universities in Michigan have agreed that they can expand to take in more students. The Michigan State University two-year college, he added "could be expanded to four years."

Mr. Scholle called the Osteopathic College Bill, "a proposal that we spend a large chunk of taxpayers' money to create an additional school and sidetrack completely what we could develop in the expansion of the two-year MSU school to a four-year university, and by increasing the number of students at Wayne State University and the University of Michigan."

". . . but for some strange reason unbeknownst to me there has been proposal after proposal, year after year, that we establish an osteopathic university." He stressed that the proposed DO college would require funds "which we haven't got."

Mr. Scholle pleaded with the legislators, "Don't impose an additional tremendous financial burden on the backs of the working class of people of this state."

MSU EXPANDS MEDICAL CLASSES TO 30 STUDENTS

MSU is enlarging the size of its entering and second-year medical classes next year from 26 to 30 students each. The move is part of a national effort to increase the physician supply and to provide additional opportunities for qualified applicants.

The increase is being made without any accompanying increase in budget or resources and a special effort is being made to admit applicants from inadequately represented geographic-economic and ethnic groups – both actions in line with recommendations from the American Association of Medical Colleges.

MSU plans to expand its classes to 64 students each when its Life Sciences building is completed in 1971. There were more than 20 applicants for every student who will begin classes in September.

CITIZENS COMMITTEE URGES EXPANSION OF MEDICAL SCHOOLS

The three Michigan medical schools can "expand rather markedly over what they are now," explained D. Eugene Sibery, chairman of the Citizens Committee on Education for Health Care, in his report October 30, 1968 to the State Board of Education.

That night, the Advisory Committee recommended that the State Board of Education continue to urge expansion of the three medical schools and "give due consideration" to creation of an osteopathic school in the state. The Committee supported efforts to create a full medical school at Michigan State University.

In commenting about the costs for medical education, Mr. Sibery said, "the committee was painfully aware of the fact that the tax bite in this state is very great."

FIVE OSTEOPATHS JOIN HOSPITAL STAFF IN FLINT

Five osteopaths have been admitted to the medical staff of Genesee Memorial Hospital in Flint, the first of their profession to be allowed to practice at a medical hospital in Genesee County. They were admitted by the Board of County Institutions, which governs Memorial and Winchester Hospitals in the Flint area.

TAKE CLINICAL TRAINING

Twenty-five medical students from Michigan State University received full-time clinical training at six hospitals in Lansing, Flint, Grand Rapids and Saginaw during the university's spring term.

Six MSMS-Sponsored Bills Survive Critical First Legislative Deadline

BY M. A. RILEY
MSMS LEGISLATIVE COUNSEL

When midnight, May 8 arrived, six of the 11 bills sponsored by MSMS had been favorably recommended for passage by the State Senate or House of Representatives. The six bills were among a total of 50 health-related proposals surviving the deadline by which proposals had to be acted upon if they were to be eligible for consideration during 1969.

Basic Science Repeal

House Bill No. 3098, which would repeal the now obsolete 1937 Basic Science Statute, was recommended for passage by the House Public Health Committee and was scheduled to be voted upon during the week of May 19. It will be remembered that this identical bill was previously passed unanimously by the Michigan House of Representatives, but failed in the Senate. Testimony presented by the Michigan Health Council did much to convince the House Public Health Committee of the destructive effect of this law on physician recruitment. All interested MSMS members are now urged to request their State Representatives to vote for the passage of HB 3098.

Society Review Committee Protection

Senate Bill No. 109, extending to committees of state, county and specialty societies the present protection of the law now granted to in-hospital committees, has been placed on the Senate action list with a favorable recommendation from the Senate Health, Social Services and Retirement Committee. This bill, requested by the MSMS House of Delegates, is of great importance to utilization review, peer review, ethics and similar committees. Members are urgently requested to seek the support of their Senators for SB 109.

Malpractice Insurance

Senate Bill No. 784, favorably reported by the Senate Commerce Committee, would permit insurers to advance monies to their insured, as an accommodation, without admitting liability by so doing; at the same time, the legal rights of the injured party would be fully protected. The bill would tend to foster settlements and to preclude lawsuits. When contacting their Senators, members should also urge support for passage of SB 784 which, along with SB 109, should be voted upon during the week of May 19.

Other MSMS Bills

An exemption from jury duty for physicians has been included in House Bill No. 3315, reported favorably by the House Judiciary Committee and scheduled for debate within the next two weeks. Also favorably reported was Senate Bill No. 560, which will improve the protection against liability of health officers and which should receive Senate attention within 10 days to two weeks. It has been previously reported that MSMS' bill to permit minors to give consent for VD treatment has previously passed the House of Representatives and is now under consideration in the Senate Health, Social Services and Retirement Committee.

MSMS bills eligible for detailed consideration by legislative committees and possible passage during the 1970 session include the "single medical practice act," a bill to license and regulate the practice of hypnosis, and three measures pertaining to medical malpractice insurance.

MSMS Favors 39 Of 50 Health Bills

The MSMS Legal Affairs Committee reviewed in detail nearly two hundred (196) health-related bills introduced in the 1969 legislative session. Of this record-breaking number, only 50 have been recommended for floor action and 39 of these are rated as deserving of support — or acceptable — by MSMS, with the number vigorously supported more than double the number opposed by the Michigan State Medical Society.

Michigan Medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00. Printed in USA. All communications should be addressed to the Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. © 1969 Michigan State Medical Society. Phone: Area Code 517, 337-1351.

Second Class Postage Paid at East Lansing, Mich. and at additional mailing offices.

MJ
NATL LIBR OF MEDICINE
8600 WISCONSIN AVE
BETHESDA 14 MD 20014

JTC:
INDEXER:
VOL-ISS:
DATE:
DEPTH:
NON-DEPTH:
RUSH:
SELECTIVE:



NATIONAL LIBRARY OF MEDICINE
RMOD. JUN 27 1969
INDEX
INPUT

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

JUNE 1969 • VOLUME 68 • NUMBER 11

MSMS-SPONSORED MEDICINE-RELIGION ACTIVITIES SPOTLIGHTED, PAGES 604-610

Read also Emergency Air-Ground System for Newborn Infants with Emergency Distress Syndrome; William Beaumont Remembered; Health Planning Conference Photo Highlights; Blue Shield Per-Case Participation Discussed.

LACTINEX®

TABLETS & GRANULES

■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(LX-05)



References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

JUNE, 1969 • VOLUME 68 • NUMBER 11

SEE TABLE OF CONTENTS ON PAGE 561

MSMS Continues to Offer Positive Alternatives To Osteopathic School Proposal in Legislature

The Michigan State Medical Society is urging Michigan Legislators to consider several positive MSMS recommendations to make wise, judicious use of state tax funds for expansion of medical education programs in Michigan.

MSMS has repeatedly urged the Michigan State Legislature to appropriate sufficient funds to the medical education programs of the University of Michigan, Wayne State University and Michigan State University to bring each to its optimum. MSMS has likewise consistently supported this program with the State Board of Education.

Supports Present Schools

MSMS has supported the expansion of the University of Michigan and Wayne State University to their capacity, and the expansion of the current two-year Michigan State University program to a degree-granting college. MSMS has urged this upon the State Board of Education, the Legislature and the Governor as the best, the quickest, and the most economical way to get the largest possible number of needed additional new physicians into practice to provide care for the people of Michigan!

MSMS is opposed to two osteopathic college bills now under consideration in the State Legislature. Substitute House Bill 2196 and Substitute Senate Bill 70 both provide for the creation of a state supported Michigan College of Osteopathic Medicine with an independent board of control. SB 70 would assign the DO college to Wayne State University as an autonomous, independent college while HB 2196 provides for an assignment of an unspecified college.

Urges Optional Degrees

MSMS has endorsed, and urged, that the matter of making an osteopathic education available to Michigan students, if they want one, be handled by offering certain educational *options* in the already-existing medical schools — so that at some point in his education each student may freely choose the degree (MD or DO) toward which he will work. Each of the medical schools has stated in communications to the State Board of Education that such a program can be developed and that each is willing to develop it.

The Michigan Osteopathic Association, however, has thus-far flatly rejected any serious exploration of an "optional degree program" in the medical schools, indeed saying that it is an impossibility. They are insistent upon a separate, autonomous college of their own and reject training as part of the medical schools which would guarantee high standards of care to the public.

Spokesmen for labor, the medical profession and other groups are telling legislators that the establishment in Michigan of a tax-supported osteopathic college is unwise. No new osteopathic school has been established in the nation in the past 50 years. There are fewer osteopathic schools and osteopathic graduates now than 13 years ago. There are five small osteopathic colleges in the nation remaining.

Estimates developed by legislative aides and others place the costs for an adequate Michigan osteopathic school between $60,000,000 and $100,000,000 during the next seven years, to graduate an annual class of 64 DOs.

Stresses Economic Aspects

"From a purely economic approach, the Michigan Legislature should endorse the proposal that the three medical schools offer students the option of an MD or DO degree, rather than establish a Michigan College of Osteopathic Medicine. For every additional dollar given to one of the three Michigan medical schools, Michigan can obtain not only more well-trained physicians or osteopaths but also more of the needed allied health professionals to serve the total medical needs of the state," according to MSMS President James J. Lightbody, M.D.



Baker's Dozen of Health-Related Bills Held from Action by State Legislature

BY M. A. RILEY
MSMS LEGISLATIVE COUNSEL

In response to testimony by MSMS and others, State Senate and House of Representatives committees have rejected action, at least for 1969, on many proposals deemed premature, unnecessary or simply adverse to good health care. Since all bills introduced in 1969 are still eligible for consideration at the start of the 1970 session these bills cannot be considered "dead."

Blue Shield - Blue Cross Focus of Many Bills

Among many proposals directly affecting Michigan Medical Service and Michigan Hospital Service were two bills (House Bills 2205 and 2206) which would have required continuing care, hospital or medical, once commenced. The bills apparently would have required unlimited benefit periods even if the contract was not maintained by the subscriber after treatment was begun. Neither bill found favor with the House Insurance Committee.

A second pair of identical bills, one in the House and the other in the Senate, provided in part that "the rate of payments made by such corporation (MMS or MHS) in behalf of such subscribers . . . . shall be subject at all times to the approval of the commissioner of insurance." Subject to interpretation that these bills would in effect be broad enough in scope to include individual fee setting by the Insurance Department, neither bill was favorably reported from committee.

House Bill 2517, which in similar form has repeatedly been rejected by previous legislatures, would have included chiropractors under those providers authorized by the Blue Shield law to furnish "definite medical and surgical care, appliances and supplies" to subscribers. Such a bill would, in effect, equate non-physicians with those who held academic degrees. The House Public Health Committee decided to retain this bill, noting that an identical bill was vetoed very recently by the Governor of New Jersey.

Generic Drug Names

A bill which would have required all pharmacists to place both the trade or brand name plus the generic name on all prescription labels was the subject of a hearing in the Senate State Affairs Committee, which then declined to act on the bill. MSMS joined several others, including the Michigan Pharmaceutical Association, in opposing the proposal deemed not only undesirable from the medical management standpoint but also both unwieldy and time-consuming.



Mrs. Sharon McAfee, secretary to MSMS Legislative Counsel M. A. Riley, balances large stack of over 3,000 health-related bills reviewed this spring by MSMS Committee on Legal Affairs.

Nursing Home Requirements

Nearly identical bills in both the Senate and House would have had the effect of exempting nursing homes from Health Department rules and regulations dealing with basic structure, facilities or numbers of patients. Considered bills which, if passed, would perpetuate undesirable existing nursing homes, neither found support.

General Subjects

Likewise held without action, in line with MSMS' position thereon, were bills which would have exempted hospitals in cities and counties with a population of 50,000 or less from hospital licensing, and which would have exempted all hospital laboratories from the laboratory licensing law of 1968.

House Bill 2130, which was not supported by the legislature, would have vested authority in the Director of Public Health to determine "distribution and merchandising of vaccines, medicines, shots or medical dosages by any person, company, corporation or society," if an epidemic was anticipated. Probably arising out of concern at the time of the 1968 Hong Kong flu epidemic, MSMS strongly opposed the sweeping authority proposed by the bill.

Comprehensive Health Planning

Labeled "premature" by MSMS and the present Comprehensive Health Planning Commission itself, as well as by the Commission's Advisory Council, bills in the House (HB 2359) and the Senate (SB 369) to cement comprehensive health planning into law were shelved for 1969 by both legislative chambers. MSMS pointed out that there is a possibility of changes in the basic federal law

CONTINUED ON PAGE 558

Second Health Planning Conference Focuses on Demands for Quality, Quantity

The overwhelming current problem that confronts the medical profession is how to meet the demand for quantity of medical services at reasonable health care costs while at the same time preserving the quality of medical services.

Ernest B. Howard, M.D., new AMA executive vice president, made that observation while delivering the opening address of the Second Annual Conference for Michigan Health Planning and Related Subjects held recently in Kalamazoo.

HIS COMMENT also summarized the subject of the conference. Nearly 150 persons Wednesday, the first day of the meeting, heard 12 speakers tackle various aspects of how to expand, improve and coordinate Michigan health care planning. Their talks were delivered at the Student Center at Western Michigan University.

A reception and buffet that evening at the Southgate Inn in Kalamazoo preceded workshops for county society leaders and three key MSMS committees.

ON THURSDAY, the second day of the conference, MSMS officers through a leadership conference learned more about federal taxes, federal funds in relation to the county society, current legislative issues, and new AMA decisions about DO interns and residents. And they heard a discussion of "The Future Relationship between Medicine and Osteopathy" by the vice speaker of the AMA House of Delegates.

Michigan Medicine devotes two of its photo pages in this issue to highlights of the conference. Selected speeches from the two-day meeting will be reprinted in the July issue.

Wayne Golf Meet July 15

The annual Wayne County Medical Society Golf Tournament is scheduled July 15 at the Western Golf and Country Club in Detroit.



The registration table, manned by MSMS Staff Assistant Helen Schulte, right, was the center of early-meeting business at the Second Annual Conference for Michigan Health Planning and Related Subjects held recently in Kalamazoo. Signing in, from left, are James J. Lightbody, M.D., MSMS president; James Imboden, AMA field representative for Michigan and Mrs. Earl E. Weston of Birmingham, president of the Woman's Auxiliary to MSMS.

DOCTOR PRATT RECEIVES WAYNE ALUMNI AWARD



Doctor Pratt

Alice E. Palmer Pratt, M.D., was one of seven distinguished Wayne State University alumni honored at the annual WSU Alumni Reunion May 17 on campus. She received an Alumni Award Citation from the WSU Alumni Association for her outstanding contributions in the field of medicine. A practicing dermatologist, Doctor Pratt is chairman of the Department of Dermatology, Grace Hospital, Detroit; senior attending physician at Detroit General Hospital and clinical associate professor at the WSU School of Medicine.

$500,000 Authorized PMAF in 1968

Another $500,000 was authorized during 1968 to further support research and educational programs of the Pharmaceutical Manufacturers Association Foundation, according to the foundation's annual report just released.

RICHARD CAMPAU NEW DIRECTOR OF NURSING HOMES

Richard Campau, former MSMS economic research consultant with the Detroit Regional Office, has taken a new position as executive director of the Michigan Nursing Homes Association. He joined the MNHA in mid-May.

Mr. Campau, who joined MSMS in 1961, has served as staff assistant for MSMS committees in socio-economic fields of work. His resignation was accepted with regret at the April 30 meeting of The Council.

Coller-Penberthy-Thirlby Program Set July 24-25

All interested Doctors of Medicine are invited to the 49th Annual Coller-Penberthy-Thirlby Medical Conference scheduled July 24 and 25 at the Park Place Hotel, Traverse City.

Hosts for the two-day meeting who have planned a stimulating professional event, will be the staff of the Munson Medical Center in Traverse City. James French, M.D., chairman of the U-M Medical School's Department of Pathology, is general chairman.

Out-of-state speakers and their topics will be:

Allan C. Barnes, M.D., professor and director, Department of Gynecology and Obstetrics, Johns Hopkins University School of Medicine, "The Management of the Postmenopause";

Lester R. Dragstedt, M.D., Ph.D., research professor of surgery and professor of physiology, the University of Florida College of Medicine, "Gastric Uulcers Produced by Vagotomy";

William A. Altemeier, M.D., professor and chairman of the Department of Surgery, The University of Cincinnati College of Medicine, "The Relationship of the Changing Pattern of Infections to Antibiotic Therapy";

Mark A. Hayes, M.D., professor of surgery, Yale University School of Medicine, "Preliminary Evaluation of Preoperative Irradiation Prior to Combined Abdominoperineal Resection for Carcinoma of the Rectum";

M. S. DeWeese, M.D., professor and chairman, Department of Surgery, The University of Missouri School of Medicine, "The Ambulance Revolution";

Merle M. Musselman, M.D., professor and chairman, Department of Surgery, The University of Nebraska College of Medicine, "Infections of the Hand";

George D. Zuidema, M.D., professor and chairman, Department of Surgery, The Johns Hopkins University School of Medicine, "Differentiation of Ascites Associated with Chronic Pancreatic Disease and with Hepatic Cirrhosis";

Paul H. Jordan, Jr., professor of surgery, Baylor University College of Medicine, "An Understanding of the Motor Dysfunction of the Esophagus," and

George E. Block, M.D., professor of surgery, and head of the Section of Head and Neck Surgery, The University of Chicago School of Medicine, "Fistulous Complications of Regional Enteritis: A Personal Consecutive Series."

Doctor Kitchell Receives Award

John H. Kitchell, M.D., Grand Haven physician and president of the Michigan United Conservation Clubs, received a 1969 American Motors Conservation Award in banquet ceremonies May 21 in Washington.

Roy D. Chapin, Jr., American Motors Board chairman, made the presentation of the bronze medallion and an accompanying $500 honorarium to Doctor Kitchell.

American Motors has labelled Doctor Kitchell "the state's foremost citizen authority on fishery resources in the Great Lakes and Michigan's inland waters." He is one of 10 non-professional conservationists to receive the 1969 awards "for dedicated efforts in the field of renewable natural resources."

Legislature Takes No Action On These Bills

CONCLUDED FROM PAGE 556

being made by the new Congress now in session in Washington and urged no action by the State Legislature at this time.

Three additional bills, which illustrate the broad scope of proposed health legislation, were held without action by legislative committees. One would have required the Department of Public Health to charge a fee of $3.00 for all laboratory examinations done by physicians; another would have required every employer in Michigan who employed 100 or more persons to maintain at all times during regular working hours a first aid center; the third would have stated the right of "freedom of choice" under all group or individual health, accident, disability, sickness or other insurance policies (or any health-care plan whatsoever), and was designed thereby to force Michigan Medical Service to recognize chiropractors. In the case of all three bills MSMS presented reasons to the appropriate committees as to why they would not be desirable legislation.

Consideration Possible in Fall

All proposals described above are, as it has been noted, still eligible for further debate in the committees holding them and possible legislative action during the 1970 session. MSMS will continue to observe the status of each, along with several dozen other bills not mentioned in this article, and present appropriate testimony at the time that any are further evaluated.

MSMAS SUMMER SEMINAR SET

The Michigan State Medical Assistants Society will stage its Summer Educational Seminar July 26-27 at the Grand Hotel on Mackinac Island. The seminar theme will be "Humanity, Humility and Humanism."



JAMES J. LIGHTBODY, M.D.
PRESIDENT, 1968-69

Let's Bring Back The Horse Sense

We hope you will excuse us for declaring a short moratorium on medical philosophic dissertations while we attempt to delve into the whimsical.

In the good old days when Sears, Roebuck catalogs were considered excellent material for "outside" reading, doctors had horses and carriages as means of transportation in making house calls and hospital visits. It was considered expedient for doctors to have dependable nags to pull their buggies to make sure they got to the spot just before the stork brought that little bundle of happiness.

MANY AND VARIED are the stories of these early pioneers of medicine as they fought their way fiercely through storms, floods and blizzards to the bedside of a person who may have had a very bad cold. Occasionally, the horse would fall dead or the carriage would disintegrate but "Old Doc" would get there "in spite of H--- and high water" — never late — never early — just in time!

Nowadays, when the only thing that frightens the horse is the sight of another horse, we are experiencing the same pitfalls of transportation as our professional forebears. Only instead of a simple horse and carriage we have a highly mobile contraption called an automobile and it looks as though the darn thing is here to stay.

All that the hardy pioneer physicians had to do to solve their motor problems was to make sure that Old Dobbin had a nosebag of oats twice a day, a few pails of water and an occasional lump of sugar.

WHAT DO WE have now? We lie awake every night during the winter wondering whether that d--- car is going to start in the morning. The biggest moment of the entire day occurs after you have pounded your way out to the garage and jumped into the front seat of the car and put your foot on the starter. Your heart leaps with joy as the cylinders gallop up and down in rhythmic ecstasy — then bang — boom — the motor gives one long expiratory wheeze and the smoke starts rolling out the exhaust pipe like it does out of the Edison smokestacks.

You wait a moment until the smog clears and you slowly lift up the hood to examine something you don't know a thing about — sort of an exploratory motorotomy. After a quick look, you decide everything is all right and you give another try and it starts — but the engine seems very noisy and you look around to see which end the cement is coming out.

You then put the car in reverse and try to back out of the garage by rotating your head a full 180 degrees — until you feel faint — and about that time the rear fender and the side of the garage get very intimate — so you force the issue and give her the gas — thereby removing the last vestigial remains of a former paint job on an accordion-pleated fender.

Then, when you add all this to such minor items as leaky radiators, flat tires, broken distributor, worn-out points, carbon on the valves (of Houston), octaneless gas, sludge in the bilge, blown mufflers, slippy clutches, sizzling gaskets, frigid-air heaters, buckled batteries, sparkless spark plugs, prolapse of the bumpers — ptosis of the water pump — and falling of the ashpan — you really got something.

OH, THE HEARTACHES of this motor age — give us less horsepower and more horse sense.

Anyway, there can never be that same mutual respect and understanding between the modern doctor and his auto as there was between the "Old Doc" and his horse — and, furthermore, we don't know of anything they have ever swept out of a garage that did anybody any good.

James J. Lightbody, M.D.

PRESIDENT'S PAGE



He is elderly, he is on corticosteroids, when he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company
Pearl River, New York

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by Michigan Medicine. Michigan Medicine will pay the first $25 of the engraving bill, and the authors shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.

6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.

7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

8. Articles should ordinarily be less than four printed pages in length (3000 words).

9. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

10. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

Michigan Medicine

IN THIS ISSUE

SCIENTIFIC ARTICLES

571 An Emergency Air-Ground System for Newborn Infants with Emergency Distress Syndrome; L. J. Arp, Ph.D.; R. E. Dillon; Mary Tom Long, M.D., and C. L. Boatwright, M.D.

575 Experience with Thyroid Malignancy in a Private Referral Laboratory; Joel I. Hamburger, M.D.

581 A Diabetic Has a Stroke; Richard D. Hohl, M.D.

581 Night Dose May Control 'Brittle Diabetic'; Jack A. Litwin, M.D.

SPECIAL ARTICLES

583 William Beaumont Experiments Remembered; Mrs. Anne Bittker

625 Holland Career Worlds Exhibition; Judith Marr

628 Doctors Discuss Blue Shield Per-Case Participation

633 Does Your Wife Belong to MSMS Auxiliary? Mrs. Edward S. Maxim

637 U-M Cancer Research and Patient Care Reviewed; Elizabeth Gall

MSMS-SPONSORED MEDICINE-RELIGION ACTIVITIES SPOTLIGHTED; Pages 604-610

PRESIDENT'S PAGE

559 Let's Bring Back the Horse Sense; James J. Lightbody, M.D.

PHOTO SECTION, Pages 617-624

OTHER FEATURES

555 Breaking News
563 Officers' Page
566 Our State Society
567 Mediscene
568 Committee Calendar
582 Monthly Surveillance Report
590 Scientific Authors
595 Members in the News
598 Michigan Authors
600 Legal
602 Socio-Economic
628 Editorial Views
648 New Members
650 Ancillary
657 In Memoriam
658 County Societies
662 Notes and Quotes

The hands on the cover of this month's MICHIGAN MEDICINE are from a lino-cut print by Robert O. Hodgell of Pass-A-Grille, Fla.

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351.

© 1969 Michigan State Medical Society.



In Cervicitis

Help the healing process with StomAseptine® douching

Helps flush away exudates, maintain internal cleanliness, reduce odor...reassures the patient

StomAseptine douching is a valuable adjunct to cervicitis therapy. These gentle, non-irritating internal irrigations help maintain a clear field by washing away pus and secretions...relieve itching and burning...reduce malodor...and offer the patient a refreshing, reassuring procedure that can help speed the healing process.



Write for new booklet on patient douching instructions; space is provided for your specific recommendations. Advise quantity needed. Write: **Harcliffe Laboratories, Inc., Dept. 1003, 423 Atlantic Avenue, Brooklyn, N.Y. 11217**

STOMASEPTINE® DOUCHE POWDER

Contains: Sodium perborate, sodium bicarbonate, sodium chloride, sodium borate, menthol, thymol, eucalyptol, methyl salicylate and aromatics—Bottles of 6 oz., 15 oz., 32 oz., Cartons of 12, 10 Gm. Packets



MICHIGAN STATE MEDICAL SOCIETY

120 West Saginaw (P.O. Box 152)
East Lansing, Mich. 48823
Area Code 517, 337-1351

1010 Antietam Road
Detroit 48207
Area Code 313, 965-0541

PRESIDENT	James J. Lightbody, M.D.	Detroit
PRESIDENT-ELECT	Robert J. Mason, M.D.	Birmingham
SECRETARY	Kenneth H. Johnson, M.D.	Lansing
ASST. SECRETARY	Brooker L. Masters, M.D.	Fremont
TREASURER	John R. Ylvisaker, M.D.	Pontiac
ASST. TREASURER	C. Allen Payne, M.D.	Grand Rapids
SPEAKER	James B. Blodgett, M.D.	Detroit
VICE-SPEAKER	Vernon V. Bass, M.D.	Saginaw
PAST PRESIDENT	Bradley M. Harris, M.D.	Ypsilanti
COUNCIL CHR.	Ross V. Taylor, M.D.	Jackson
VICE-CHAIRMAN	Ralph R. Cooper, M.D.	Detroit

COUNCILORS:

Sidney Adler, M.D.	1st	Detroit
Ralph R. Cooper, M.D.	1st	Detroit
Don W. McLean, M.D.	1st	Detroit
Milton R. Weed, M.D.	1st	Grosse Pointe Park
Robert K. Whiteley, M.D.	1st	Detroit
Ross V. Taylor, M.D.	2nd	Jackson
Harvey C. Hansen, M.D.	3rd	Battle Creek
Don Marshall, M.D.	4th	Kalamazoo
John R. Pedden, M.D.	5th	Grand Rapids
Harold H. Hiscock, M.D.	6th	Flint
John J. Coury, M.D.	7th	Port Huron
A. Carl Stander, M.D.	8th	Saginaw
Robert V. Daugharty, M.D.	9th	Cadillac
Edward H. Rodda, M.D.	10th	Bay City
Brooker L. Masters, M.D.	11th	Fremont
Wm. A. LeMire, M.D.	12th	Escanaba
J. Robert Franck, Jr., M.D.	13th	Wakefield
Harold F. Falls, M.D.	14th	Ann Arbor
Sydney Scher, M.D.	15th	Mt. Clemens

EXECUTIVE DIRECTOR	Hugh W. Brenneman	East Lansing
ASSOCIATE EX. DIR.	Warren F. Tryloff	East Lansing
GENERAL COUNSEL	Lester P. Dodd	Detroit
LEGAL COUNSEL	A. Stewart Kerr	Detroit
ECON. CONSULTANT	Clyde T. Hardwick	Detroit
HISTORIAN	Wm. J. Stapleton, Jr., M.D.	Detroit
ASS'T HISTORIAN	Wm. M. LeFevre, M.D.	Muskegon

SCIENTIFIC EDITOR
John W. Moses, M.D., Detroit

EXECUTIVE EDITOR
Herbert A. Auer

MANAGING EDITOR
Judith Marr

ASSOCIATE SCIENTIFIC EDITORS
Frederick J. Cady, Jr., M.D., Surgery
Saginaw
Robert M. Daugherty, M.D., Basic Science
East Lansing
Harold E. De Pree, M.D., Medicine
Kalamazoo
Dean C. Elliott, M.D., Otolaryngology
Petoskey
Tommy N. Evans, M.D., Obst.-Gyn.
Detroit
Dorin L. Hinerman, M.D., Pathology
Ann Arbor
Samuel D. Jacobson, M.D., Medicine
Detroit
Benjamin Jeffries, M.D., Psychiatry
Detroit
Raymond S. Kurtzman, M.D., Radiology
Detroit
A. Martin Lerner, M.D., Medicine
Detroit
George H. Lowrey, M.D., Pediatrics
Ann Arbor
Carl A. Moyer, M.D., Surgery
Baraga
Charles E. Parkinson, M.D., Radiology
Battle Creek
John C. Pierce, M.D., Medicine
Grand Rapids
Frank H. Power, M.D., Surgery
Traverse City
J. G. Turcotte, M.D., Surgery
Ann Arbor
Alexander J. Walt, M.D., Surgery
Detroit
Park W. Willis, III, M.D., Medicine
Ann Arbor
Richard E. Wunsch, M.D., Medicine
Traverse City

Publication Committee

Brooker L. Masters, M.D.
Harvey C. Hansen, M.D.
William A. LeMire, M.D.
Don Marshall, M.D.
Don W. McLean, M.D.
Edward H. Rodda, M.D.
Milton R. Weed, M.D.

What makes a woman cry?

A man?
Another woman?
Three kids?
No kids at all?
Wrinkles?
You name it.

Is she truly depressed?

Is that why she lets go in your office?

You comfort her.
Talk to her.
And, if she is depressed, consider Pertofrane.
Because
in 3 to 5 days
she can often begin
to cope,
work,
maybe play,
even enjoy.

Pertofrane®

desipramine hydrochloride
In depression...
when words are not enough



But before you prescribe Pertofrane, please see the full prescribing information and especially note Contraindications, Precautions, Warning, Adverse Reactions and Dosage. A brief summary of that information is included here.

Pertofrane® desipramine hydrochloride

Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg. in bottles of 100 and 1000. (B) 46-530-E

For complete details, please see the prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Muskegon Doctors Initiate Study Of Michigan Medical Service

Members of the Muskegon County Medical Society will be happy to send copies of their factual and opinion surveys of Michigan Medical Service to other interested physicians and county medical societies around the state, according to Frank L. Pettinga, MCMS president. The results of the Muskegon surveys will be published at a later date in MICHIGAN MEDICINE.

Members of the Muskegon County Medical Society (MCMS), dissatisfied with their relationship with Michigan Medical Service (MMS), have begun a two-phase study of MMS service in their locality. They are aiming at building "an arsenal filled with facts regarding the effectiveness of MMS as a medical insurance carrier."

When the MCMS delegates attend the annual session of the Michigan State Medical Society next fall "we trust they will be armed with the consensus of opinion of all the physicians of Muskegon County regarding third party interference in the practice of medicine," writes Frank L. Pettinga, M.D., MCMS president, in a recent county bulletin editorial.

In his article Doctor Pettinga charges MMS or Blue Shield with asserting dictatorial power, misrepresenting its services in its advertising, entering into a program of harassment of non-participating physicians, intimating that the individual physician is so immature and greedy that he has no right to evaluate his own services and set a fair fee, and exhibiting on its claims a "frequency of inaccuracies that has been inexcusable."

"The doctors of this community know that their relationship with Blue Shield is not healthy," writes Doctor Pettinga. "But the actual diagnosis and the severity of the disease has not been documented. The Board of Directors of Muskegon County Medical Society decided to obtain the facts and initiated the formations of an in-depth study of the relationship of the doctors of the community with Michigan Medical Service and other third parties." The study was announced at a monthly society meeting.

Both phases of the study were launched in April.

The first phase is an accounts receivable analysis of Blue Shield participation on an account and cash-amount basis by offices voluntarily cooperating with the local society. It is a simple monthly summary record to be kept by each participating office with a central advisory center for assistance and is to continue at least six months.

The second phase involves a task force of 10 physicians who will visit every active society member to help him complete three questionnaires: the first a factual questionnaire of each physician's role and experience, the second an opinion survey to permit expression of a physician's attitudes and desires (to be tabulated and compared among each MCMS member), and the third a non-directed, written expression of additional or amplifying opinions related to the entire study and its eventual compilation and use.

"Blue Shield seems to be loyal to the ideal of providing money for the care of its individual subscribers, but in practice appears to be interested primarily in the power that it has in establishing policies governing the subscribers and the physicians," says Doctor Pettinga.

Specifically, the Muskegon County doctors are setting out to prove their allegations that Blue Shield only rarely pays a claim before three weeks; as it advertises, and that many claims are not paid in three months, sometimes not after six months.

Blue Shield drives a wedge between patient and doctor by keeping the physician's profile from him, they say, thereby intimating that his immaturity and greed give him no right to evaluate and set his own fees. Blue Shield drives another wedge between physician and patient by asking that patients report to MMS if a doctor's fee comes to more than Blue Shield gives the patient to cover the fee, thereby causing the patient to suspect the doctor's price.

"We trust that our delegates will be instrumental in initiating an evolution in the role that Michigan Medical Service plays in the total picture of medical care of people of Michigan. This evolution will take MMS out of the role of master and place it back in the role of ally with a primary purpose of service and will prevent the revolutions that will otherwise be inevitable," concludes Doctor Pettinga.

OUR STATE SOCIETY

Michigan Mediscene

June 4 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

June 19-21 — 74th ANNUAL MEETING OF THE UPPER PENINSULA MEDICAL SOCIETY, Indianhead Mountain Ski Chalet, Wakefield-Bessemer.

June 24 — CAUCUS OF AMA DELEGATES AND ALTERNATES, MSMS Headquarters, East Lansing, 4:30 p.m.

June 27-28 — Annual Summer Meeting of the Michigan Orthopedic Society, Hidden Valley, Gaylord.

July 13-17 — American Medical Association Annual Meeting, New York City.

July 24-25 — 49th Annual Coller-Penberthy-Thirlby Medical Conference, Park Place Motor Inn, Traverse City.

July 26-27 — Michigan State Medical Assistants Society Summer Educational Seminar, "Humanity, Humility and Humanism," Grand Hotel, Mackinac Island.

July 31-Aug. 2 — Midsummer Meetings of Medical and Health Organizations of Michigan, Boyne Mountain Lodge, Boyne Falls.

July 31-Aug. 2 — MSMS Midsummer Session of the Council, Boyne Mountain Lodge, Boyne Falls.

Sept. 15-16 — 29th Annual AMA Congress on Occupational Health, Stouffer Riverside Inn, St. Louis.

Sept. 28-Oct. 3 — MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION, Sheraton-Cadillac Hotel, Detroit.

Sept. 30-Oct. 2 — Annual Convention, Woman's Auxiliary to MSMS, Hotel Pontchartrain, Detroit.

Oct. 1 — MSMS COUNCIL, Sheraton-Cadillac Hotel, Detroit.

Oct. 8-11 — 12th National Conference on Physicians and Schools, Pick-Congress Hotel, Chicago.

Oct. 12 — AMA Midwestern Regional Conference on "Voluntary Health Agencies and American Medicine," Stouffer Hotel, Indianapolis.

Nov. 12 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

Nov. 30-Dec. 3 — American Medical Association Clinical Convention, Denver.

Dec. 17 — MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

Mark Your Calendar Now...
104th ANNUAL
SCIENTIFIC SESSION
MICHIGAN STATE
MEDICAL SOCIETY
Detroit, October 1-2

Many Items Reprinted From Michigan Medicine

Items that appear in *Michigan Medicine* are often reproduced in other publications for a variety of purposes. Requests were recently received for permission to reprint all of the following:

A copy of an article formerly printed in the March 1967 issue of *Michigan Medicine* has been sent to the Nursing Education Department of Ravenswood Hospital Medical Center School of Nursing in Chicago. Mary Jane Watson, R.N., of the department recently requested the copy of "Community Psychiatry and the Future State Hospital," by Von Brauchitsch.

Another article which appeared not long ago in *Michigan Medicine* will soon be read in Portuguese.

G. M. Hetherington, Manager, Promotion Planning and Training, Parke, Davis and Company, recently notified MSMS that the article, "A New Antipyretic Agent," by Charles F. Weiss, M.D., F.A.A.P., and Scott T. Harris, M.D., F.A.A.P., which appeared in the November, 1967 issue of *Michigan Medicine,* will be translated for use by the Rio de Janeiro Branch of Parke, Davis.

Permission has been granted to a former *Michigan Medicine* contributor to use an illustration in a new book he is writing. A figure that accompanied R. G. Bickford's article, "Sensory Precipitation of Seizures," in the September, 1954, issue of *Michigan Medicine* will now go into a chapter of Mr. Bickford's new book, *Basic Mechanisms of the Epilepsies,* that he is preparing for publication.

Copies of the article by William H. Carlyon, Ph.D., "What Is This Thing Called Health Education?" which appeared in the November, 19698, issue of *Michigan Medicine* have been distributed to 217 secondary schools in the Out-Wayne County area.

The Wayne County Department of Health gave out the copies in support of comprehensive health education seminars which will be offered this summer at Wayne State University and the University of Detroit. Doctor Carlyon, author of the article, is Consultant in Health and Fitness for the AMA.

COMMITTEE CALENDAR

Every month many MSMS committees meet to develop new projects and to move along activities approved by The Council or suggested by the House of Delegates. Following is a calendar of May, June and future meetings for The MSMS Council, MSMS committees and other official groups.

Thursday-Sunday, May 1-4
MSMS Committee on Emergency and Disaster Medical Services
Sheraton-Cadillac Hotel, Detroit
Chairman: Charles P. Anderson, M.D., Detroit

Wednesday, May 7
MSMS Committee on Cancer
MSMS Headquarters, East Lansing
Chairman: M. E. Dodds, M.D., Flint

Wednesday, May 7
Michigan Cancer Coordinating Committee
MSMS Headquarters, East Lansing
Chairman: C. Fred Arnold, Detroit

Sunday-Monday, May 22-23
MSMS Annual Maternal Health Conference
Kellogg Biological Station, Gull Lake
Chairman: James E. Harryman, M.D., Muskegon

Wednesday, June 4
MSMS Council
MSMS Headquarters, East Lansing
Chairman: Ross V. Taylor, M.D., Jackson

Wednesday, June 25
Caucus of AMA Delegates and Alternates
MSMS Headquarters, East Lansing
Chairman: Donald N. Sweeny, Jr., M.D., Detroit

Thursday-Saturday, July 31-Aug. 2
MSMS Midsummer Session of The Council
Boyne Mountain Lodge, Boyne Falls
Chairman: Ross V. Taylor, M.D., Jackson

Wednesday, Oct. 1
MSMS Council
Sheraton-Cadillac Hotel, Detroit
Chairman: Ross V. Taylor, M.D., Jackson

Wednesday, Nov. 12
MSMS Council
MSMS Headquarters, East Lansing
Chairman: Ross V. Taylor, M.D., Jackson

Wednesday, Nov. 12
MSMS Committee on Cancer
MSMS Headquarters, East Lansing
Chairman: M. E. Dodds, M.D., Flint

Wednesday, Nov. 12
Michigan Cancer Coordinating Committee
MSMS Headquarters, East Lansing
Chairman: C. Fred Arnold, Detroit

Wednesday, Dec. 17
MSMS Council
MSMS Headquarters, East Lansing
Chairman: Ross V. Taylor, M.D., Jackson

QUACKERY EXHIBIT HAS GOOD RESPONSE

MSMS's public service exhibit on quackery drew a favorable response to its stay this spring at the Detroit Bank and Trust Co. Darwin D. Martin, Jr., assistant vice president of the bank wrote to MSMS: "This has been a very interesting exhibit and one which has drawn a great deal of attention. We appreciate greatly the opportunity to display it and thank you for your interest in the bank."

Michigan Medicine, MSMS Commended

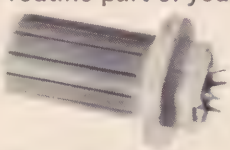
MSMS has been commended recently for its work in promoting through the pages of **Michigan Medicine** the projects of Easter and Christmas Seal campaigns.

Catherine Bauer, director of public relations for the National Easter Seal Society for Crippled Children and Adults, thanked MSMS "for the fine coverage you gave the Easter Seal Campaign in **Michigan Medicine.** This is very important help to the work for crippled children," she said, "and we are most grateful to you for it."

Sincere gratitude to MSMS was extended by the board of trustees of the Michigan Tuberculosis and Respiratory Disease Association through a formal resolution presented at the East Lansing headquarters of MSMS. With it came a plaque to **Michigan Medicine** "for outstanding service toward improving community health in the fight against tuberculosis and other respiratory diseases."

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY

ANDROID — GOOD TO EXCELLENT 75%

PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android

Each yellow tablet contains:

Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 10 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.

Dose: 1 tablet 3 times daily.

Available:
Bottles of 100, 500, 1000.

Android-HP

HIGH POTENCY

Each red tablet contains:

Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.

Dose: 1 tablet 3 times daily.

Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . . 64 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.

Dose: 1 or 2 tablets daily.

Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (¼ gr.) . . . 15 mg.
Thiamine HCL . . . . . 25 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Glutamic Acid . . . . . 100 mg.
Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 . . . . . 2.5 mcg.
Riboflavin . . . . . 5 mg.

Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

also available with ESTROGEN

Android-E

Each Tablet Contains:

Methyl Testosterone . . . . . 2.5 mg.
Ethinyl Estradiol . . . . . 0.02 mg.
Thyroid Ext. (1/6 gr.) . . . . . 10 mg.
Thiamine Hydrochloride . . . . 10 mg.
Glutamic Acid . . . . . 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road — Conducted by Sisters of Mercy — Ann Arbor, Michigan

Telephone — 313 663-8571

Mercywood MERCY

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

Lyle M. Allis, M.D.
Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.*
Sydney Joseph, M.D.
Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Richard D. Watkins, M.D.
Stephen C. Mason, M.D.
Philip M. Margolis, M.D.
Hubert Miller, M.D.

* 1904 - 1967


Darvon®
Compound-65
Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.

This paper describes an emergency air-ground transport system which has been used successfully to transport newborn infants with Respiratory Distress Syndrome to the Roanoke Memorial Hospitals at Roanoke, Virginia.

The special equipment which has been developed for ventilating the distressed newborn will not be available commercially for about one year. In an effort to make this equipment available immediately to physicians and the distressed infants, the Virginia Polytechnic Institute at Blacksburg, Virginia, has established an emergency air-ground transport system. A twin engine airplane equipped with special respiratory support equipment will be available to physicians who may wish to transfer respiratory distress cases to the Intensive Care Nursery at the Roanoke Memorial Hospitals.

All members of the flight crew donate their time to this service without charge, and V.P.I. makes no charge to the patient or to the doctor for transporting the infant to the hospital.

An Emergency Air-Ground System For Newborn Infants With Emergency Distress Syndrome

Editor's Note: This article will appear in its entirety in the May-June and July-August issues of *Anesthesia and Analgesia*. The present article is being submitted to 20 state medical journals within flying range of the center. This paper is being presented here to acquaint our readers with the possible use of this service. John W. Moses, M.D.

BY L. J. ARP, Ph.D., R. E. DILLON, MARY TOM LONG, M.D., AND C. L. BOATWRIGHT, M.D.
ALL OF BLACKSBURG, VA.

Respiratory distress in the newborn infant has been the largest single cause of death during the first week of life. About 17% of all premature infants are affected by respiratory distress and about half of these die. About 25,000 infants expire each year in the United States.[1] This number represents between 30% and 40% of all newborn deaths.[2] Nearly half of the infants weighing less than 3½ pounds who now survive their respiratory distress may be mentally defective.[3] J. F. Lucey, M.D., writing in the January, 1968 issue of "Hospital Practices," cites a study carried out at the Boston Lying-In Hospital where it was found that mortality among premature infants accounted for 71% of all liveborn infant deaths. The death rate in low birth weight infants was said to have shown ". . . no improvement in 21 years . . . ."

These grim statistics do more than suggest that high risk infants delivered in the average hospital in this country face great hazards. Indecision, uncertainty, and delay in resuscitation and treatment can result in irreversible anoxic tissue damage to the brain and other vital organs. The tragic results, many times ascribed to immaturity rather than anoxia, are known all too well. The wait-and-see, hands-off procedures, using oxygen and buffer

Doctor Arp is professor of industrial engineering and chairman, Division of Engineering Fundamentals, Virginia Polytechnic Institute Blacksburg, Va. Mr. Dillon is instrument supervisor and Doctor Long is with the Student Health Service at the institute, while Doctor Boatwright is a private practitioner in Blacksburg.



SCIENTIFIC PAPERS



Figure 1. The V.P.I. Airplane

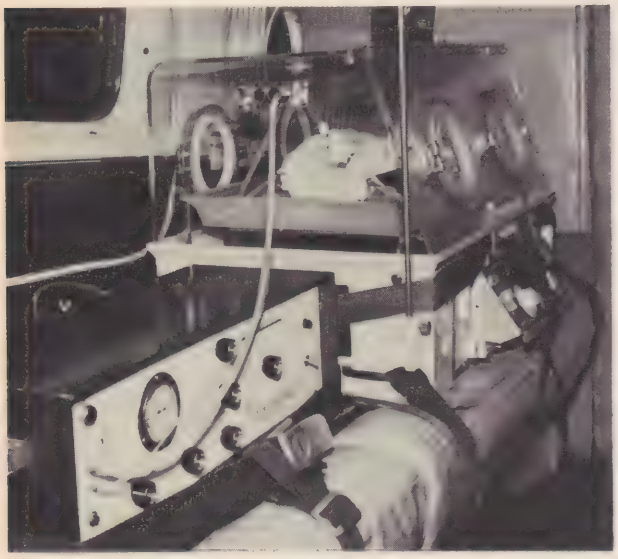


Figure 2. The Arp Infant Respirator and the Armstrong Servo-Control Incubator

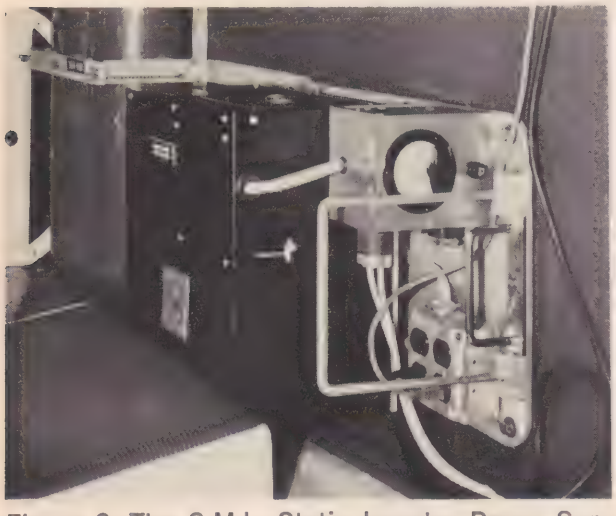


Figure 3. The C.M.L. Static Inverter Power Supply

therapy alone for treating respiratory distress has been proved inadequate by experience.

Newborn Intensive Care Nurseries are needed throughout the country. However, the specially trained personnel and new equipment designed specifically for the newborn infant are not generally available.

A dramatic decrease in infant morbidity and mortality rates has been achieved when nursing personnel, trained in the use of a special infant respirator, blood-gas, and physiological monitoring equipment, have been available.[4, 5] The average survival rate which can be expected for all infants weighing no more than 1,000 grams (2 pounds-3 ounces) is about 10% to 15%.[6] These figures include those not afflicted with Respiratory Distress Syndrome (R.D.S). In contrast, the survival rate for infants weighting no more than 1,000 grams, with all 19 infants with respiratory distress, in a study by Arp, et. al., was 31.7%.[4, 5] Special equipment for treating the distressed infant provided a similar striking improvement in the survival rate for infants weighting no more than 1,500 grams (3 pounds-5 ounces) where the normal survival rate for all infants in this weight group, including those who were not in respiratory distress, is about 29.3%.[6] The survival rate in the study by Arp, et. al., for 42 infants, with all infants in respiratory distress, and weighing no more than 1,500 grams, was 47.6%.[4, 5]

A PLAN FOR THE IMMEDIATE FUTURE

It is unlikely that every hospital will be able to assemble and train a team of specialists to cope with the vexing problems associated with the distressed newborn in the very near future. In addition, the special infant respirators needed for the successful treatment of newborn Respiratory Distress Syndrome will not be generally available for some time. Blood-gas analyzing and physiological monitoring equipment is expensive and requires very skilled and specially trained nurses and/or technicians. Personnel with this specialized training are not readily available.

The most difficult problem to solve, however, is that of convincing the nursing supervisors and the hospital administrators that each distressed newborn must have a graduate or licensed practical nurse for uninterrupted observation and attention as long as the physician carries the infant on the "critical" list. Each graduate or licensed practical nurse can manage 2 infants only after the patient is removed from the "critical" list.

In view of the requirements just outlined, it becomes very clear that all hospitals cannot, in the very near future, support and operate an intensive care nursery as it must be structured in order to reduce today's tragic infant morbidity and mortality rates. Intensive care nurseries must be established in population centers to provide the

best medical care known today to the largest number of people. Infants from less populated areas will need to be transported to these specially staffed and equipped intensive care nurseries.

New transport systems must be devised to reduce the time and risks involved in moving the high risk patients to the centers before the patient becomes critically ill. Pysicians will be called upon to make the decision to transfer patients long before they can be absolutely certain that the patients will not survive in the average hospital. The patients must be viable when they arrive at the intensive care nursery. New equipment and techniques cannot perform the miracle of restoring life to the dead.

A very general plan has been outlined for supplying the best medical care known for the distressed newborn. This plan has been put into operation by the Virginia Polytechnic Institute, (V.P.I.), Blacksburg, Virginia, in cooperation with the Roanoke Memorial Hospitals, Roanoke, Virginia.

A NEW TRANSPORT SYSTEM FOR INFANTS WITH R.D.S.

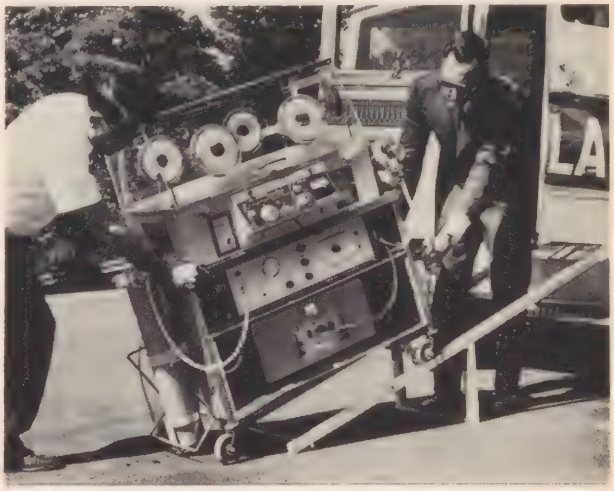
A twin engine Beechcraft airplane has been made available by V.P.I.'s President, T. Marshall Hahn, Jr., for transporting newborn infants with respiratory distress from hospitals lacking the needed specialized staff and equipment to the Intensive Care Nursery at the Roanoke Memorial Hospitals. The transport service described in the following pages will be available at the request of physicians and without charge until the new infant respirator become available commercially. The V.P.I. airplane can land at any hard surfaced airport having a runway at least 2,800 feet long. The runway must be lighted for a night flight. The service may be obtained any time of the day or night that the airplane and infant respirators are not in use. To obtain this service or information, call Doctor L. J. Arp, Area Code 703-552-6571 or Area Code 703-552-1162, or Mr. R. E. Dillon, Area Code 703 - 552-2507.

Figures 1, 2, and 3 show the airplane equipped with an Arp Infant Respirator, an Armstrong Servo-Control Incubator,* a solid state static inverter** to convert the airplane's 28 volt power supply to 117 volts, and a redundant oxygen supply. The volunteer flight crew includes the pilot, E. S. Warner, the Co-pilot, Bill Byrne, L. J. Arp, Ph.D., R. E. Dillon, and Mary Tom Long, M.D., or C. L. Boatwright, M.D.

When a request is received for emergency air transportation for a distressed infant, the physician in charge of the transfer is requested to "stand-by" at the hospital with the infant in a warm incubator containing an atmosphere of 100% oxygen. As the pilot approaches the pick-up point and a precise landing time becomes known, the control tower is requested to call the waiting physician to give him the landing time. If refueling is required the completion time for this operation is passed on to the physician so that there is no delay in the transfer of the infant to the airplane system.



Figure 4. The Transport Ambulance System


Figure 5. Respiratory Support Continues Uninterrupted Throughout Transfer

The infant in respiratory distress is transferred to the special holding and positioning fixture in the Armstrong Incubator. A restraining blanket is placed around the holding fixture as a safety belt for the infant. After respiratory assistance is started with the Arp Infant Respirator, using a nose mask as the patient-machine interface,[4, 5] the airplane is ready to take off for the Roanoke airport.

As the pilot nears the Roanoke airport and the arrival time becomes known the control tower is requested to notify the Intensive Care Nursery at the Roanoke Memorial Hospitals of the arrival

* Supplied by: Ohio Medical Products, Inc., 1400 E. Washington Avenue, Madison, Wisconsin.

** Supplied by: Communications Measurements Laboratory, Inc., 350 Leland Avenue, Plainfield, New Jersey.

time. **Figure 4** shows the specially equipped ambulance with redundant oxygen supply, a battery powered inverter to supply 117 volts, alternating current to power the incubator and the self-contained respirator which is dispatched with a nurse from the Intensive Care Nursery to meet the arriving patient.

The incubator is transferred from the airplane to the ambulance support system without interrupting respiratory assistance. The ambulance support system is then rolled up a special ramp into the waiting ambulance (**Figure 5**). The entire portable unit is then clamped securely in place to prevent any shifting of the unit during the trip from the airport to the hospital. Respiratory assistance remains uninterrupted as the infant is transferred from the ambulance, up the elevator, and into the Intensive Care Nursery.

Use of the battery powered respiratory support unit from the ambulance is not limited to the transfer of distressed infants from the airport to the hospital. This unit is used to supply respiratory support for infants during transfer from near-by hospitals to the Intensive Care Nursery when it is either impossible or impractical to use the airplane.

The portable unit is on stand-by in the delivery suite and in surgery for all deliveries and Caesarean sections. The unit is also used to supply uninterrupted respiratory support while the infant is transported to the X-ray department, during radiological observations, and while using the X-ray intensifier. It has been observed that an interruption in respiratory support for even a minute or two can trigger irreversible changes in the patient which will cause death.

CONCLUSIONS

The degree of success in reducing newborn infant morbidity and mortality by supplying respiratory assistance is directly related to the condition of the infant at the time he is provided that assistance. It has been found that the transfer is generally an exercise in utter futility if the referring physician delays in transferring the distressed infant until he is quite sure that the infant will not survive in the local hospital nursery.

The concept of the absolute necessity for an early transfer and start of intensive and comprehensive support for the distressed infant has been most difficult to convey. The last-ditch stand by a physician using oxygen and buffer therapy has been proved by experience to be inadequate in many cases. No surgeon waits for a vermiform appendix to perforate before taking a patient into surgery. Likewise, the infant with R.D.S. has the best chance for survival if respiratory assistance is started immediately after the first clinical signs of trouble are observed.

The integrated air-ground transport and support systems described in this paper have been used successfully. The key to this successful operation is teamwork. This teamwork can only be accomplished through education, training, and dedication to the idea that better treatment is possible and can become a reality through cooperative understanding and advanced planning. Once the hardware and support teams are available, the only obstacles remaining in the path leading toward success are indecision and delays.

REFERENCES

1. Avery, M. E.: The Lung and Its Disorders in the Newborn Infant, Philadelphia, W. B. Saunders Co., 1964.
2. Carlson, D. L.: Engineering Aspects of Neonatal Respiratory Augmentation, Unpublished thesis, Ames, Iowa Library, Iowa State University of Science and Technology, 1964.
3. Lucey, J. F.: The Newborn Special Care Unit in the Community Hospital Setting, *Hospital Practices,* 27, (Jan.) 1968.
4. Arp, L. J.; Dillon, R. E.; Humphries, T. J.; and Pierce, D. E.: A New Approach to Ventilatory Support of Infants with Respiratory Distress Syndrome, Part I, The Arp Infant Respirator, *Anesthesia and Analgesia,* (May-June) 1969.
5. Arp, L. J.; Dillon, R. E.; Humphries, T. J.; and Pierce, D. E.: A New Approach to Ventilatory Support of Infants with Respiratory Distress Syndrome, Part II, The Clinical Applications of the Arp Infant Respirator, *Anesthesia and Analgesia,* (July-Aug.) 1969.
6. Yerushalmy, J.: The Low-Birthweight Baby, *Hospital Practices,* 68, (May) 1968.

Experience with Thyroid Malignancy In a Private Referral Laboratory

BY JOEL I. HAMBURGER, M.D.
SOUTHFIELD

Between 1961 and 1968 the author has encountered 89 patients with thyroid malignancy. This paper will consider the composition of this series in terms of sex, age at diagnosis, manner of presentation, therapy employed, and results of therapy. Although this is not one of the larger groups of thyroid malignancies to be reported, this work does represent the personal observation of a single physician, and in this regard differs from most publications on this subject. The lessons the author has learned should be of value to all physicians who encounter thyroid patients.

MATERIALS AND METHODS

During the period between July, 1961, and December, 1968, approximately 7,000 thyroid patients have been seen in the course of providing a thyroid diagnostic and therapeutic laboratory facility for referrals from physicians of metropolitan Detroit. Each patient was at least briefly interviewed by the author to obtain pertinent history. Physical examination appropriate to the clinical picture was performed. In every instance the thyroid gland was palpated for size, consistency, and nodularity, and adjacent lymph nodes were sought. For patients who had undergone prior thyroid surgery for nodular goiter an attempt was made to obtain reports of the histological examinations from either the attending physicians or the hospitals. For patients presenting with thyroid nodules for whom biopsy was advised, follow up was attempted to determine whether surgery was undertaken, and if so, the histological diagnoses.

IN THIS FASHION, 89 patients with a diagnosis of thyroid malignancy were discovered. **Table 1** gives the breakdown as to age, sex, and histologic diagnosis. It is our policy to classify thyroid malignancies as follows:

1. Differentiated;
2. Hurthle cell;
3. Medullary;
4. Anaplastic;
5. Lymphoma;
6. Metastatic to the thyroid from a primary elsewhere.

TABLE 1

AGE, SEX AND HISTOLOGIC DIAGNOSIS IN 89 THYROID CANCER PATIENTS

Age Years	Male	Female	Total	Differentiated	Hurthle Cell	Medullary	Anaplastic	Lymphoma
< 10	0	2	2	2	0	0	0	0
10-19	3	4	7	6	0	1	0	0
20-29	7	13	20	20	0	0	0	0
30-39	4	17	21	21	0	0	0	0
40-49	2	17	19	17	0	1	1	0
50-59	5	5	10	9	1	0	0	0
60-69	2	3	5	4	1	0	0	0
70 +	0	5	5	1	0	0	3	1
Total	23	66	89	80	2	2	4	1

In the differentiated group are included papillary, follicular, and mixed types of thyroid carcinomas. These are not subclassified since our experience is in accord with that which suggests that the prognosis for tumors of this general category is related primarily to factors other than the precise determination of the relative preponderance of papillary and/or follicular elements.[1] Two patients with Hurthle cell tumors have been separately classified. Although Hurthle cells can occur in any tumor, and this type of tumor is generally considered a variant of follicular carcinoma, the separate classification for the two patients in this series is justified on the basis that the lesions were almost entirely made up of this type of cell, were very large, and in one of the patients demonstrated persistent tendency to recur and metastasize in spite of repeated surgery and radiation therapy.

The rest of the terminology conforms to that employed in standard classifications of thyroid malignancy.

Seven patients gave a history of prior radiation therapy to the thymus or neck area.

TO EVALUATE the location and 131-I concentrating capacity of residual thyroid tissue after

Doctor Hamburger is director of the Northland Thyroid Laboratory in Southfield and of the Nuclear Medicine Laboratories of Highland Park General and North Detroit General Hospitals.

surgery for thyroid malignancy, 131-I scanning is performed after the patient has been without thyroid hormone medication for six weeks. Therapy with 131-I is considered whenever there is uptake in the neck outside the preoperative confines of the thyroid gland (exclusive of clear-cut pyramidal lobe activation), uptake in distant metastases (primarily pulmonary, or osseous), or for uptake limited to the preoperative confines of the thyroid gland, but in an area near the primary lesion. Prior to therapy attempts are made to increase the 131-I uptake in the tissue to the maximum by permitting endogenous TSH stimulation over the six week period. Since 1966 intensive diuresis with mannitol (originally), or ethacrynic acid (more recently) has been employed as an adjunct to further increase 131-I uptake. The mannitol technique has been published previously,[2] and since this has been superseded by the ethacrynic acid regimen, only the latter will be outlined:

1. For five days the patient is placed upon an iodine deficient diet consisting of the following foods: lean beef or veal, lake trout, peas, cauliflower, fresh tomatoes, onions, cucumbers, lettuce, fresh apples, fresh pears, oranges, rice, boiled potatoes, milk 1 or 2 glasses, water, coffee, chocolate;
2. For the first four days of the program the patient is given ethacrynic acid, 50 mg every eight hours;
3. While on ethacrynic acid the patient also takes sodium chloride, 12 gm daily in divided doses, and 4,000 ml of water;
4. TSH, 10 units intramuscularly may also be given on the four days of ethacrynic acid treatment if the patient is not overtly hypothyroid;
5. The RAI uptake is repeated between the fifth and sixth days. If there is significant augmentation of uptake then the regimen is repeated, however, the therapy is administered on the morning of the fifth day.

Patients who receive 131-I therapy are given substitution levothyroxine beginning three days after the treatment. Within six to twelve months levothyroxine is discontinued and repeat tracer studies are performed to evaluate the effects of the therapy. After 131-I therapy is completed, at annual intervals the patients are examined, or their physicians contacted, to assess their course.

RESULTS

Table 2 summarizes the presentation of the 89 thyroid cancer patients. For 24 the diagnosis had been made at surgery prior to our initial contact with the patient. The interval between the primary surgery and our first evaluation varied from one month to 19 years. Nine patients were seen within one year, an additional three patients were seen between one and five years, and the remaining twelve patients were seen six years or more after the original diagnosis of thyroid cancer had been established. These patients were generally referred for further evaluation of the status of the malignancy; but in three patients the diagnosis was discovered as the result of our policy to obtain routinely surgical records on any patient with a thyroidectomy scar regardless of the reason for his referral.

In 51 patients a nodule was detected in a clinical setting suggesting cancer. Scanning with 131-I revealed the nodule to be hypofunctional, and the diagnosis of thyroid malignancy was established histologically.

TEN PATIENTS had palpable nodules in the neck which were thought to be pathological lymph nodes. There were no palpable nodules in the thyroid gland proper. For nine of these patients the lesion proved to be metastatic thyroid cancer from primary lesions too small to be detected by physical examination. The remaining patient had a follicular cancer in the apex of a tiny pyramidal lobe.

In two patients the discovery of thyroid cancer was incidental to surgery for large goiters with obstruction. A third patient was operated upon for a solitary hypofunctional nodule which proved to be a parathyroid adenoma. However, adjacent to this lesion was a small papillary thyroid cancer. A fourth patient had surgery for a 3 cm autonomous hyperfunctioning thyroid nodule, in the center of which was an 0.5 cm papillary cancer.

Table 3 demonstrates the size, as estimated on palpation, of thyroid nodules which proved to be malignant. The majority of differentiated lesions were between 2 and 4 cm in diameter. The anaplastic and Hurthle cell tumors were considerably larger.

Table 4 shows that there was a disproportionately great incidence of malignant nodules in the upper poles, and a smaller incidence of malignant nodules in the isthmus, in comparison with the distribution of 425 consecutive unselected discrete thyroid nodules.

Table 5 gives the results of surgery for the 89 thyroid cancer patients in terms of postoperative scanning. Patients with residual 131-I uptake in cervical nodes, pulmonary metastases, or in the area of the primary lesion (even if limited to the preoperative confines of the thyroid gland) were treated with 131-I. Those with residual tumor which did not concentrate 131-I were advised to have external radiation therapy.

Table 6 summarizes the treatment which was received by the 89 patients. Repeat surgery was advised for two patients with small palpable recurrences in the neck which took up 131-I so poorly that no significant therapeutic benefit was

TABLE 2

MANNER OF PRESENTATION OF 89 CANCER PATIENTS

Diagnosed at previous surgery		24
Hypofunctional nodule		51
Suspected pathological lymph node		10
Incidental to thyroidectomy for other indications		4
Obstructing goiter	2	
Parathyroid adenoma	1	
Autonomous thyroid nodule	1	

TABLE 3

NODULE SIZE OF LESIONS IN OR ADJACENT TO THE THYROID BY HISTOLOGIC TYPE

Nodule Size cm	Differentiated	Medullary	Hurthle Cell	Anaplastic	Lymphoma
< 1	5	1	0	0	0
1-1.9	7	1	0	0	0
2-2.9	22	0	0	0	0
3-3.9	10	0	0	0	0
4-4.9	3	0	0	1	0
5-5.9	1	0	1	0	0
6-6.9	0	0	0	1	1
7+	0	0	1	2	0

TABLE 4

LOCATION OF DISCRETE THYROID NODULES, MALIGNANT AND RANDOM

	Malignant			Random		
		total	%		total	%
RUP	7	15	33	35	70	16
LUP	8			35		
RMP	3	6	13	35	67	16
LMP	3			32		
RLP	12	23	51	129	230	54
LLP	11			101		
Isthmus	1		2	58		14
Total	45			425		

TABLE 5

RESULTS OF SURGERY IN 89 THYROID MALIGNANCY PATIENTS DETERMINED BY POST-OPERATIVE SCANNING

After attempted total thyroidectomy		60
No 131-I uptake	10	
131-I uptake in thyroid bed remote from primary	10	
131-I uptake confined to thyroid bed, but in area of primary	11	
131-I uptake in cervical nodes	21	
No scan done	8	
After limited surgery		10
131-I uptake in contralateral lobe only	4	
131-I uptake confined to thyroid bed, but in area of primary	4	
131-I uptake in cervical nodes	1	
No scan done	1	
Extent of surgery unclear, no scan done		11
Biopsy only		8
Total		89

TABLE 6

POST-OPERATIVE THERAPY
89 THYROID MALIGNANCY PATIENTS

131-I (followed by levothyroxine)		36
with diuretic preparation	18	
without diuretic preparation	18*	
External radiation therapy (followed by levothyroxine)		9
Thyroid hormone alone		29
Repeat surgery		2
Treatment unknown		13
Total		89

* One patient received external radiation therapy prior to 131-I (not our advice).

TABLE 7

RESULTS OF 131-I ABLATIVE THERAPY WITHOUT DIURETIC PREPARATION

Patient	Pre-Therapy 24-h 131-I uptake %	Dose 131-I mc	Result
R.B.	2	175	clear*
E.H.	2	150	clear
R.D.	2	200	clear
C.W.	2	200	2%
B.M.	3	150	clear
B.B.	4	150	clear
P.A.	5	150	clear
N.R.	5	200	clear
J.L.	5	150	clear
R.E.	7	150	clear
A.G.	14	150	clear
S.S.	15	100	clear
M.W.	15	150	clear
R.S.	26	100	2%
	2	200	2%
S.K.	8	200	clear

* i.e., no residual 131-I uptake above background level.

TABLE 8

RESULTS OF DIURETIC PREPARATION ON 131-I UPTAKE IN PATIENTS WITH INOPERABLE THYROID CANCER

Patient	Diuretic	Pre-Diuretic 24-h 131-I Uptake %	Post-Diuretic 24-h 131-I Uptake %
R.S.	mannitol	2	2
C.W.	mannitol	2	2
L.M.	mannitol	4	12
M.G.	mannitol	6	14
M.M.	mannitol	6	15
H.F.	mannitol	9	27
A.K.	mannitol	16	33
L.B.	mannitol	16	34
D.H.	mannitol	19	38
M.A.	ethacrynic acid	2	3
D.M.	ethacrynic acid	2	3
N.T.	ethacrynic acid	2	6
R.M.	ethacrynic acid	3	7
P.C.	ethacrynic acid	3	5
J.H.	ethacrynic acid	4	7
P.A.	ethacrynic acid	5	7
I.B.	ethacrynic acid	5	12
D.H.	ethacrynic acid	5	9
I.R.	ethacrynic acid	6	14
G.O.	ethacrynic acid	6	12
C.K.	ethacrynic acid	7	21
J.K.	ethacrynic acid	8	17
J.W.	ethacrynic acid	9	32
D.C.	ethacrynic acid	15	37
R.R.	ethacrynic acid	28	45

thought possible from this form of treatment. Thyroid hormone was regularly employed after radiation therapy, or for patients who had no apparent residual tumor after surgery, or who were considered unsuitable for any other treatment.

Table 7 gives the results of 131-I therapy without diuretic preparation, and for patients who failed to respond to diuretic preparation. Of 15 patients for whom post-131-I therapy data is available, incomplete ablation was detected in two patients, one of whom had two doses of 131-I.

TABLE 9

131-I UPTAKE % THROUGH 96 HOURS BEFORE AND AFTER PREPARATION WITH ETHACRYNIC ACID

Patient	131-I uptake % before ethacrynic acid preparation			131-I uptake % after ethacrynic acid preparation		
	24-h	48-h	96-h	24-h	48-h	96-h
R.R.	28	25	23	45	40	37
D.H.	5	5	5	9	9	7
J.K.	8	9	8	17	25	26
N.T.	2	1	1	6	6	3
I.B.	5	5	4	12	13	8
J.W.	9	8	8	32	38	30

TABLE 10

COMPARISON OF UPTAKES AFTER TSH* AND AFTER ETHACRYNIC ACID, WITH AND WITHOUT CONCOMITANT TSH

Patient	Preliminary 24-h 131-I uptake %	24-h 131-I upt. % after TSH	24-h 131-I uptake % after ethacrynic acid with or without TSH
J.W.	9	15	32[x]
J.H.	4	4	7[y]
D.M.	2	3	3[y]
D.C.	15	21	37[x]
C.K.	7	8	21[y]

* TSH 5 units daily IM for five days

x TSH and ethacrynic acid

y Ethacrynic acid alone

TABLE 11

RESULTS OF 131-I ABLATIVE THERAPY WITH DIURETIC PREPARATION

Patient	Pre-Therapy 24-h 131-I Uptake %	Dose 131-I mc	Result
N.T.	6	200	clear
R.M.	7	200	clear
D.H.	38	100	5%
	9	200	clear
G.O.	12	150	clear
I.B.	12	200	clear
M.G.	14	150	clear
M.M.	15	150	clear*
J.K.	17	150	clear
A.K.	33	150	clear
L.B.	34	75	clear
J.W.	32	150	clear
R.R.	45	100	clear

* Small amount of activity recognizable within the thyroid bed area, but uptake in cervical nodes eliminated.

TABLE 12

CAUSE OF DEATH IN 9 THYROID CANCER PATIENTS

Cerebrovascular disease	2
Cardiac	2
Anaplastic thyroid	3
Lymphoma	1
Lung cancer	1

Table 8 summarizes the effects of diuretic preparation on 131-I uptake in 25 patients with inoperable thyroid cancer. Nine patients received mannitol as a diuretic agent. Seven of the patients had significant increases in uptake after this preparation. However, the mannitol regimen was unpleasant, required intravenous administration, and hospitalization. In addition, one patient ruptured a berry aneurysm and expired following a fit of retching and vomiting after receiving mannitol.[3] For these reasons, more recently ethacrynic acid has been employed as the diuretic agent. With this method, the requirement for intravenous medication and hospitalization has been eliminated. Of 16 patients so prepared, two- to threefold increases in uptake were produced in nine patients, lesser increases were produced in three patients and responses from minimal to nil were observed in the remaining four patients. One patient developed a transient aplastic anemia following treatment with ethacrynic acid. There were no other significant complications.

Table 9 shows that the increased 131-I uptake which follows diuretic preparation is not a temporary phenomenon, but is maintained through 96 hours, at least to the same degree as the pre-diuretic uptake.

Table 10 provides data indicating that the diuretic augmentation of 131-I uptake is additional to that obtained with TSH.

Table 11 gives the results of 131-I therapy after diuretic preparation in the 12 patients for whom follow up data is available. Of particular interest are patients NT, RM, and DH, who were successfully ablated with diuretic preparation, when the pre-diuretic uptake was low enough to raise concern for the success of the planned ablative therapy.

Nine patients have died during the period of this study. **Table 12** gives the cause of death. One additional patient with anaplastic cancer is near terminal, and another with a Hurthle cell tumor has widespread metastases, but remains ambulatory. No patients have died from differentiated tumors as yet.

DISCUSSION

Thyroid malignancy is a relatively uncommon disease. Of approximately 7,000 thyroid patients seen over a seven year period, only 89 had cancer or history of cancer. Had it not been for routine searching of old records, the number would have been substantially smaller. Its rarity not withstanding, seldom does a month go by without a new publication on this subject. The reason for

this apparent undue interest in an uncommon condition undoubtedly relates to the frequency of nodular goiter, and the necessity for deciding which nodules should be treated surgically. Although this may be a difficult decision, with experience it can be made with considerable accuracy.[4]

No metastatic thyroid cancers were seen. This is predominantly an outpatient series. Since patients with metastatic cancer to the thyroid would more likely be seen in hospitalized patients or at post-mortem, this absence may be understandable.

A smaller than usual proportion of tumors were of the anaplastic type. The usual incidence of anaplastic tumors is in excess of ten percent.[5, 6, 7] Even if we exclude the 24 patients diagnosed prior to our first contact, our incidence of anaplastic lesions would be only six percent. We believe that this predominance of small differentiated tumors reflects, at least in part, some of the policies of our laboratory. All patients referred to us, even just for blood tests of thyroid function, are seen by a physician for careful examination of the neck. As a result unrecognized thyroid nodules have been detected in a number of patients. Six thyroid cancers were discovered by routine examination of the thyroid.

THIS SERIES demonstrates a point often overlooked. There is a tendency to think that thyroid cancer patients present with either a lump in the neck, or symptoms of metastases, either local, or to lung or bone. However, many of the patients seen in the average physician's office will have only a scar on the neck to alert him to the possibility of this diagnosis. One might think that these patients have already been treated, hence the matter is irrelevant. Our experience is just the contrary. Of 15 patients encountered from 1 to 15 years after the initial diagnosis of thyroid cancer, six required additional treatment for the cancer which had not been undertaken. Since residual thyroid cancer may remain asymptomatic for years, particularly if confined to the neck, all patients who have a history of thyroid cancer should have their problem reviewed periodically by physicians who deal with this problem on a regular basis. Thinking on the treatment of thyroid cancer has been in a continual state of flux for the last 20 years and undoubtedly will remain so for the foreseeable future. Therefore, it is difficult for the physician not primarily involved in thyroid diseases to remain abreast of these changes. Periodic consultation will assure his patient the benefit of new developments.

It has been said that thyroid cancer originates most frequently in or about the isthmus, particularly at the junction of the isthmus with the lobes of the gland.[8] Other than this reference there is very little in the literature which would suggest that the site of a nodule has any relationship to the likelihood of malignancy. Hence the observation that upper pole nodules are more likely, and isthmus lesions are less likely to be malignant is worthy of note. It will take further experience before this can be established as actual fact.

SEVEN PATIENTS gave a history of prior radiation therapy to the neck. In three, this was to the thymus gland within the first two years of life, in a fourth, the tonsils were treated at age five years, two had X-ray therapy for acne, one at age 12 years and one at age 23 years, and a seventh patient had X-ray therapy for Bell's palsy at age 17 years. This last patient developed thyroid cancer on the same side of the neck as the Bell's palsy. The time lapse for the development of these tumors was between 10 and 15 years.

Two patients with autonomous nodules had thyroid cancer. One of these patients had an 0.5 cm diameter lesion in the center of a large autonomous nodule. The other had an autonomous nodule in the left lower pole, while the cancer was in the midportion of the right lobe. Previously we reported a review of the literature to show that adequate supporting data for an autonomously functioning thyroid cancer had yet to be reported, and was theoretically unlikely.[9] In our two cases there is nothing to suggest that the cancers were other than coincidentally related to the autonomous nodules.

The indications for 131-I therapy following surgery for thyroid cancer are still arguable. Although prophylactic ablation of all residual tissue capable of 131-I uptake has been advised,[10] such a policy would require giving large doses of 131-I to many patients unnecessarily. It is difficult to compare the potential risks with the possible benefits of such a program, since there is inadequate data on both points. For the present, we agree with Bonte[11] who advises against prophylactic ablation of remnants of probably normal thyroid tissue.

External radiation therapy is a second choice to 131-I therapy, and is contraindicated until every effort is made to induce uptake of 131-I by inoperable thyroid cancer. Premature administration of external radiation may impair 131-I uptake by tumor tissue without destroying the capacity of that tissue metastasize. External radiation has been employed for anaplastic thyroid cancer, lymphoma, and rarely for residual differentiated tumor which cannot be induced to concentrate 131-I.

A COMPARISON of the results of 131-I therapy in patients responding to diuretic preparation and those treated without this preparation is difficult. There are not enough of the former patients and enough time has yet to elapse for such a comparison. Nevertheless, it seems clear that if 131-I therapy is to be administered the maximum possible uptake should be obtained prior to the treatment. One must recognize that ablation of function does not necessarily mean ablation of tumor growth or metastatic potential. Therefore,

even though ablation of function was achieved in most patients without diuretic preparation, the benefits from 131-I therapy will remain undetermined for many years because of the natural history of differentiated thyroid cancer. Even when the preliminary 131-I uptake is satisfactory to permit 131-I therapy, diuretic preparation is worth considering, in the hope of accomplishing the ablation of residual tissue with a lesser total dose of 131-I.

Since our preliminary report on the use of mannitol to augment 131-I uptake in inoperable thyroid cancer a number of criticisms of the method have been offered. These include the possibility that the increased uptake might be only a transient phenomena,[12] and that similar increases in uptake have been reported with the use of TSH.[13] The data in **Table 9** indicates that maintenance of the increased uptake persists through at least 96 hours to the same degree as the uptake prior to diuretic preparation. **Table 10** clearly shows that the increase in uptake produced by diuretic preparation is additional to that obtained with TSH. Of course, the methods are not mutually exclusive and in selected patients might well be employed together.

Although no patients in our series have died as a result of differentiated thyroid cancer, the duration of follow up is too short and the ultimate prognosis will have to be determined after a long-term follow up.

SUMMARY AND CONCLUSIONS

Between 1961 and 1968, 89 patients with thyroid malignancy were encountered by the author. There were 80 differentiated tumors, two Hurthle cell lesions, two medullary lesions, four anaplastic tumors, and one lymphoma. The majority of the differentiated lesions occurred between the ages of 20 and 60. The anaplastic lesions all occurred after age 40. The ratio of females to males in this series was approximately three to one. There was a disproportionately large incidence of malignancy in upper pole nodules and a reduced incidence in nodules which occur in the isthmus. Thirty-six patients were advised to have 131-I therapy following surgery. Eighteen of these patients had significant increases in 131-I uptake by inoperable tumor following diuretic preparation. Diuretic preparation should be considered for all patients with inoperable thyroid cancer for whom 131-I therapy is planned.

REFERENCES

1. Till, A. S. Types of carcinoma of the thyroid and their presentation. Brit. J. Surg. *52*:734, 1965.
2. Hamburger, J. I. and Desai, P. Mannitol augmentation of 131-I uptake in the treatment of thyroid carcinoma. Metabolism. *15*:1055-1058, 1966.
3. Hamburger, J. I. Complication of mannitol augmentation of 131-I uptake in inoperable thyroid cancer. Metabolism. *16*:676-677, 1967.
4. Shimaoka, K., Badillo, J., Sokal, J. E., and Marchetta, F. C. Clinical differentiation between thyroid cancer and benign goiter. J. Am. Med. Assoc. *181*:179, 1962.
5. Black, B. M., YaDeau, R. A., and Woolner, L. B. Surgical treatment of thyroidal carcinomas. Arch. Surg. *88*:610, 1964.
6. McGovern, J. B. and Mannix, H. Thirty-year surgical experience with thyroid cancer. N.Y. State J. Med. *67*:2207, 1967.
7. Smithers, D. W., Howard, N., and Trott, N. G. Treatment of carcinoma of the thyroid with radioiodine. Brit. Med. J. *2*:969, 1965.
8. Sloan, L. W. and Frantz, V. K. In: Werner, S. C., ed. The Thyroid, 2 ed. New York, Hoeber, p. 454, 1962.
9. Miller, J. M., Hamburger, J. I. The thyroid scintigram. I. The hot nodule. Radiology, *84*:66-74, 1965.
10. Haynie, T. P., Nofal, M. M., and Beierwaltes, W. H. Treatment of thyroid carcinoma with 131-I. J. Am. Med. Assoc. *183*:303, 1963.
11. Bonte, F. J. Radioiodine in the child with thyroid cancer. Am. J. Roentgenol. *95*:1, 1965.
12. Editorial comment. Mannitol augmentation of 131-I uptake in the treatment of thyroid carcinoma. Metabolism. *15*:1055, 1966.
13. Editor, J. Am. Med. Assoc. Personal communication.

A 54-year-old known diabetic was seen for the first time in the Emergency Room with a tentative diagnosis of a cerebrovascular accident. He was confused, restless, and had a left hemiparesis. While a spinal tap was being performed, a blood sugar report of 25 mg. per 100 ml. was returned from the laboratory. Following the administration of 2 ampules of 50% dextrose, the hemiparesis resolved and normal mentation returned.

"A Diabetic Has a Stroke"

BY RICHARD D. HOHL, M.D.
DETROIT

Hypoglycemia may masquerade as any number of neurologic and/or psychiatric affections. While insulin therapy is the most common cause of a lowered blood sugar, the widely used sulfonylurea antidiabetic drugs may also induce varying degrees of hypoglycemia, which occasionally is unusually prolonged.

A patient may transcend the classical autonomic syndrome of hypoglycemia, i.e. weakness, sweating, and palpitations, manifesting rather a protean, often bizarre and dramatic neurologic and/or psychiatric disorder: obstinance and distinct behavioral changes are seen in children and young adults with growth-onset or "juvenile-type" diabetes, whereas diplopia, visual blurring, hemiparesis, or loss of consciousness tend to characterize the non-autonomic neurologic syndrome attending hypoglycemia in older, more stable diabetic patients. Frank convulsive seizures may occur at any age, denoting intense hypoglycemia with cerebral deficiency of glucose.

The administration of concentrated glucose intravenously simultaneously affords both an effective bedside diagnosis as well as a specific remedy for the hypoglycemic state. Laboratory confirmation is helpful *only* when the blood sugar is obtained *during* the episode. However, treatment should not be withheld pending a laboratory report of the blood glucose level in any instances where hypoglycemia is suspected, as delay in treatment carries a risk of serious, permanent damage to the central nervous system.

Doctor Hohl is with the Department of Metabolism, Henry Ford Hospital, Detroit.

CLINICAL AXIOM

Neurologic and/or psychiatric states which develop in any diabetic patient known to be receiving insulin or an oral antidiabetic sulfonylurea agent are hypoglycemia until proven otherwise.

Night Dose May Control 'Brittle Diabetic'

BY JACK A. LITWIN, M.D.
DETROIT

Many patients who are considered brittle diabetics are not really brittle but rather difficult to control only because they or their physicians are reluctant to use a night dose of intermediate insulin in addition to their daily morning dose.

How many times have we tried in vain to control insulin-dependent patients with unstable diabetes by a single dose of insulin, gradually increasing the amount only to precipitate hypoglycemic symptoms at 4 P.M. and hyperglycemia the following morning.

PHYSICIANS SHOULD recognize the fact that the commonly-used intermediate insulins, NPH and Lente, may not exert a significant hypoglycemic effect over a full 24-hour period. In many patients this important fact must be explained fully to the patient.

How does one determine whether or not a patient requires a night dose? By obtaining a fasting, 11 A.M. and 3 P.M. blood sugar, one can clarify the nature of the diabetic state. If the blood sugars at 11 A.M. and 3 P.M. are satisfactory (i.e. less than 150 mg %) while the fasting blood sugars are persistently elevated, a second smaller dose of insulin is given sometime in the evening, usually at bedtime or, with some patients, before supper. In this regard, the physician is best guided by when the evening hyperglycemia occurs.

How much insulin?

VARIOUS RATIOS FOR the "split dose" have been advocated, including 2:1 or 3:1 (i.e. 45 units NPH before breakfast and 15 units NPH at bedtime or suppertime.) My personal preference is to start with 5 units of NPH or Lente in the evening, reducing the morning dose by a comparable amount. The increase in the evening dose is guided by the fasting blood sugars, while the morning dose is adjusted by measuring the blood sugar at 3 P.M. Gradually the patient comes under control and, lo and behold, that brittle diabetic is no longer brittle!

MICHIGAN DEPARTMENT OF PUBLIC HEALTH

MONTHLY SURVEILLANCE REPORT
CASES OF CERTAIN DISEASES REPORTED
TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
FOR THE FIVE-WEEK PERIOD ENDING MAY 2, 1969

	1969 This 5-Week Period	1968 Same 5-Week Period	1969 Total To Above Date	1968 Total Same Date	Total Cases for 1968
Measles	33	46	108	157	352
Whooping Cough	9	56	50	186	429
Diphtheria	—	—	—	—	—
Mumps	848	2,593	2,484	9,390	14,655
Scarlet Fever & Strep Sore Throat	1,323	1,241	4,509	5,104	10,101
Tetanus	—	1	1	1	5
Poliomyelitis (paralytic)	—	—	—	—	3
Hepatitis	345	185	1,095	609	2,356
Salmonellosis (Other than S. typhi)	42	58	144	205	614
Typhoid Fever (S. typhi)	2	—	3	—	1
Shigellosis	25	26	108	71	346
Aseptic Meningitis	6	5	34	20	265
Encephalitis	11	4	32	31	114
Meningococcic Meningitis	18	7	52	37	94
H. Influenzal Meningitis	3	5	14	19	64
Tuberculosis	258	274	821	1,036	2,647
Syphilis	474	531	1,608	1,947	5,351
Gonorrhea	1,638	1,572	5,891	5,733	18,153

Information can be supplied by the local health department of the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health



A detail of the painting, "Beaumont and St. Martin," by Dean Cornwell, above, depicts the U.S. Army Surgeon, William Beaumont, with his patient, the French voyageur, Alexis St. Martin.

The following article details the life story of William Beaumont, M.D., who has been called the first significant American physiologist. Doctor Beaumont was a U.S. Army Surgeon stationed at Mackinac Island when, in June, 1822, a young French-Canadian voyageur was wounded at close range by a shotgun blast and came under Doctor Beaumont's care. The wound healed leaving an open fistula into the stomach, enabling Doctor Beaumont to make observations on digestion and the gastric juices which made a lasting contribution to medicine. The article is reprinted from the Fall, 1968 issue of YALE MEDICINE, with the permission of the publisher.

MEDICAL HISTORY MADE ON MACKINAC ISLAND

William Beaumont Experiments Begun 147 Years Ago This Month

BY MRS. ANNE BITTKER
ASSOCIATE MANAGING EDITOR
YALE MEDICINE

It would be hard to imagine a more unlikely alliance than that of the eminent Dr. William Beaumont and Voyageur Alexis St. Martin. But once met, their paths were to cross and recross and the world of medicine would be the beneficiary. Beaumont is often referred to as "the father of gastric physiology"; St. Martin was his reluctant laboratory-patient whose open fistula was to divulge and confirm a mass of data on digestion and the gastric juices.

William Beaumont came from a family whose ancestors in Lebanon, Connecticut, had been thriving farmer-landowners of strong religious and political views. Born in 1785 and raised on the family property, he had no interest in farming. In his early years, he attended the town's common school, showing proficiency in English and Latin. At 21, he took leave of his family to travel northward without plan or destination but with provi-

sions — a horse-drawn cutter, a barrel of cider and $100 — plus a desire to see some part of the world and to have an effect for good in it.

In 1807 he arrived at Champlain, New York, a small mill town near the Canadian border, on the Great Chazy River. Beaumont settled here and applied to the village trustees to teach at the local school. For three years, his winters were spent educating the youth of Champlain; his summers, clerking in the village store; and every evening, reading in medical books borrowed from the library of Dr. Seth Pomeroy, a highly regarded practitioner in nearby Burlington, Vermont. Beaumont's introduction to medical learning crystallized his plans for the future. He would teach until he had sufficient funds to underwrite the two-year apprenticeship required to obtain a medical certificate. In 1810 he was accepted by Dr. Benjamin Chandler of St. Albans. Chandler, a gifted surgeon, not only undertook the instruction of young Beaumont but gave him room and lodging. He systematically drilled his own son as well as his boarder in such medical fundamentals as symptoms, diagnoses, the writing of prescriptions and the arts of cupping and bleeding. Beaumont repaid his teacher and host by sweeping the office, washing bottles, making up pills and assisting in operations. He also began the practice of keeping a detailed notebook and medical journal, a procedure which he continued throughout much of his professional life. Entered in the journals were his personal observations, often-used prescriptions, notes on important diseases, and remarks on matters medical, either quoted by his teacher or selected from his reading.

/"Sept. 8th 1912 — Quit my Precepter, Doc Benjn Chandler, St. Albans, Vt. under whose friendly inspection & instruction I happily pursued my medical studies for 2 years, to my own satisfaction & that of my Precepter . . ."/

Having completed his apprenticeship, he was granted a license to practice by the Third Medical Society of the State of Vermont. The outbreak of the War of 1812 led him to enlist as a surgeon's mate. He was attached to the 16th Regiment of the infantry at Plattsburgh, then transferred in November with a division to Sackett's Harbor. His opportunities for practice occurred at once, for the conditions which the arriving army endured were miserable. Few had tents and, since the terrain was wet, cold and muddy, Beaumont had ample experience in the treatment of rheumatism, dysentery, typhus, pleurisy and pneumonia.

/"(My) treatment of the foregoing diseases I am warranted in adapting — from the happy issue & successful termination of more than two hundred cases out of which not one has died while under my care. . ."/W.B., Nov. 1812

He was plunged into surgery, too, when at the Battle of York, the British exploded several hundred barrels of powder in the path of advancing Americans. Sixty were killed instantly and 300 wounded. Beaumont went into action at once, together with Dr. Daniel, the hospital Surgeon General, and operated without let-up for forty-eight hours.

/". . . The wounds were of the worst kind — compound fractures of legs, thighs, & arms & fractures of skulls — on the night of the explosion, we were all night engaged in amputating & dressing the worst of them — .the next day also and the day after I performed four amputations & 3 trepanings . . ."/W.B., April 1813

CITED FOR BRAVERY

His next engagement, for which he and his fellow surgeon mates were cited on account of their "cool bravery" was at the Battle of Plattsburgh in service under General Alexander Macomb.

/". . . During the investment of Plattsburgh by the enemy the surgeons were constantly passing from fort to fort or to blockhouses to dress the wounded, exposed to a crossfire of round and grape shot while the greater part of the army was covered by fortifications . . . I feel myself bound to report with much respect, the conduct of all medical gentlemen attached to this army . . . and who for their particular services . . . merit the applause of their country. . ."/Surg. James Mann to Surg. James Tilton

With the signing of the Treaty of Ghent, and the reduction of the standing army, Beaumont found that life on the base in peacetime held neither sufficient stimulation for his mind nor scope for his profession. He resigned to enter private practice, this time in Plattsburgh, where he had good friends, including a cousin, Dr. Samuel Beaumont, and where news of his army duty proficiency had preceded him. For a few years he shared jointly in a medical practice and in the operation of a small general store selling groceries, ammunition and medicines.

Meanwhile a colleague and former military surgeon, Dr. Joseph Lovell, was selected to become the first Surgeon General of the U.S. Army in Washington. Eager to reorganize the service and to surround himself with similarly capable men, he sought out Beaumont for a clerkship. The latter was tempted but turned down the offer of ad-

". . . I happily pursued my medical studies for two years. . ."

ministrative work to continue in practice. On the other hand, Lovell's reorganization of ratings made army medical service a good deal more attractive than previously and Beaumont made application for readmission and received orders to proceed to Fort Mackinac, once again under General Macomb. At his own request, an additional proviso permitted him to attend the non-military residents of the Island since he was the only doctor in the area.

/"Secretary of war has no objection to your giving your professional services to the sick of Mackinac, provided it does not interfere with your official duties. They can not, however, be furnished from the public chest."/Surg. Gen'l. to W.B.

Mackinac Island, located in a commanding position on Lake Huron, had long been an important and colorful center for Indians, misionaries and fur traders. Here in the village settlement was the headquarters of the American Fur Company. Here, every June and July thronged Indians, French-Canadians; an assortment of fishermen, trappers and traders bringing their goods and wares down rivers and streams to be sold or traded and temporarily swelling the island population by thousands. The wild parties, brawls and fights resulting from their short-lived accumulated winter's earnings added considerably to the calls made on Dr. Beaumont's time. The Army surgeon continued to maintain his journal with assidious attention to detail, both medical and otherwise, and so we know that life on the post and in the village was very much to his liking, but for his wistful references to a handsome and talented young widow back in Plattsburgh, Mrs. Deborah Green Platt, to whom he had become deeply attached while in practice there.

/". . . oh how long doth seem our separation — anxious indeed am I to know our final prospects — were our present happy anticipations to be destroyed & our hopeful heart-sustaining prospects cut off — oh how cheerless — difficult & desperate would be the future scenes of life . . ."/W.B., 1820

In the autumn of 1821 Beaumont requested and received a brief furlough at which time he journeyed to Plattsburgh and shortly after returned to the island with Deborah as his bride.

The voyageurs and trappers had just arrived at Fort Mackinac the following year, June 6th of 1822 when, in the milling crowd gathered in the company store, a shot gun was accidentally discharged at close range and Alexis St. Martin, a young French-Canadian in the employ of the American Fur Company, collapsed to the floor with a gaping chest wound. Dr. Beaumont was summoned and examined the patient.

"The man can't live 36 hours. I will come to see him bye and bye."

"LARGE AS A TURKEY'S EGG"

/". . . found a portion of the lung as large as a Turkey's egg, protruding through the external wound, lacerated and burnt; and immediately below this, another protrusion which, on further examination, proved to be a portion of the stomach lacerated through all its coats and pouring out the food he had taken for his breakfast through an orifice large enough to admit the fore finger . . ."/W.B.

According to an eye witness of the shooting, after painstakingly removing some of the shot, fragments of clothing and cleansing and superficially dressing the wound. Beaumont departed, saying "The man can't live 36 hours. I will come to see him bye and bye." Beaumont's own recollection, as recorded in his notebook, is a much more pessimistic one.

/". . . I considered any attempt to save his life entirely useless. But as I had ever considered it a duty to use every means in my power to preserve life when called to administer relief, I proceeded to cleanse the wound . . . not believing it possible for him to survive twenty minutes . . ."/W.B.

The relationship initiated by Beaumont's life-giving care to young St. Martin was to transform the doctor from an able army surgeon and practitioner to the foremost physiologist of his day whose observations, according to some, were America's first contribution to medicine. An interdependency would develop between his reluctant patient and himself which was to be a source of frustration and aggravation to both.

For nearly a year Beaumont visited the fort's frame hospital to minister to his patient and to dress his wounds daily, noting down meticulously his own treatments and the consequent reactions in St. Martin's well-being, comfort and appearance. Then, officials of the county announced that they were neither able nor willing to give further support for Alexis' upkeep; that he would have to be returned to his place of origin. Knowing that the helpless youth could never survive the 1,500-mile trip by canoe to lower Canada, and touched by his miserable situation, Beaumont offered to take him into his own home. This could not have been an easy decision for his army salary of $40.00 a month plus rations was already stretched to cover the support of his wife and year-old daughter, Sara.

/". . . I took him into my own family . . . at a time when he was helpless, sick, and suffering under the debilitating effects of his wounds, naked and destitute of everything, but pain, a 'little

breath of life' and a wounded body . . ."/W.B., 1823

There are sources who claim that from his second visit to St. Martin, Beaumont entertained the idea of experimentation on the boy by introducing food into the stomach via the fistula. Beaumont, whose journals are revealing and explicit, had this to say:

/". . . To retain his food and drinks I kept a compress and tent lint, fitted to the shape and size of the perforation and confined there by adhesive straps. After trying all the means in my power for eight or ten months to close the orifice, by exciting adhesive inflammation in the lips of the wound, without the least appearance of success, I gave it up as impracticable in any other way than that of incising and bringing them together by sutures; an operation to which the patient would not submit."/W.B.

In the fall of the following year, the doctor sent his observations to his friend and superior, Joseph Lovell, for approval and possible publication, and "A Case of a Wounded Stomach" by Joseph Lovell appeared in an 1825 issue of *The Medical Recorder*. Misassignment of authorship was due, in all probability, to Lovell's updating of St. Martin's condition rather than to any literary piracy on the part of the Surgeon General. The final paragraphs indicated Beaumont's growing awareness of the rare opportunity available to him to make use of his human laboratory for the advancement of mankind.

/". . . This case affords an excellent opportunity for experimenting upon the gastric fluids and process of digestion. It would give no pain, nor cause the least uneasiness to extract a gill of fluid every two or three days, for it frequently flows out spontaneously in considerable quantities. Various kinds of digestible substance might be introduced into the stomach, and then easily examined during the whole process of digestion . . ."/W.B.

He had, as he noted in the body of the article, already established certain data about the functioning of gastric juice. Careful observer that he was, without any formal plan for experimentation, he had begun to question and to reject some of the erroneous but accepted concepts, replacing them with verified facts.

"This case affords an excellent opportunity for experimenting. . ."

An exchange of correspondence with Lovell who offered him encouragement and assistance fortified his own feelings about the importance of his investigations but, simultaneously, triggered his sense of isolation from scientific circles and heightened his awareness of the inadequacy of his surroundings and equipment for carrying on experimentation. He therefore applied for, and eventually received a transfer to the hospital at Fort Niagara. The post being near Plattsburgh, Mrs. Beaumont and the children (now two in number) visited her family's home while the doctor embarked on the first of a series of digestive experiments involving St. Martin.

The patient was then well enough to perform odd jobs for his patron, including wood-cutting and other household chores, but with renewed health he had little taste for or understanding of his role as physiological guinea pig. A two-month furlough to Plattsburgh with the doctor brought Alexis close to the Canadian woods which he did know and understand and he bolted, leaving no word or trace.

DESPAIR AND DISAPPOINTMENT

Beaumont's despair and bitter disappointment over his loss was great, but having alerted the agents of the fur companies and their employees, his furlough over, the doctor was forced to return to duty at Fort Niagara. A second transfer carried him further west to Fort Howard at Green Bay, another trading center. Beaumont's chief concern at the post was in preventing the spread of smallpox, the possibility of an epidemic always threatening due to the nomadic lives of the Indians and traders of the area.

Two years elapsed before Beaumont's inquiries about his patient were to be answered: through an agent of the American Fur Company, Mr. William Morrison, the doctor was advised that Alexis, healthy but destitute, was living in Berthier, Lower Canada, with a wife and two children; that if his wife could be engaged by the Beaumonts, he would gladly place himself at the doctor's disposal. Two more years were to elapse before patron and patient were reunited. Beaumont had been transferred to Fort Crawford at Prairie du Chien which necessitated a trip of several months down various waterways for the voyageur and his family and a financial advance on the part of the doctor.

/". . . He now entered my service, and I commenced another series of experiments on the stomach and gastric fluids, and continued them interruptedly until March, 1831 . . ."/W.B.

In March, his wife pleading extreme homesickness, Alexis and his family departed for Canada — with permission — on his promise to return on request. It was Beaumont's plan to obtain a year's furlough and to travel with St. Martin to Europe to share with physiologists and chemists on the

continent the data he had gathered and to gain further insights from their studies and observations. Permission for both furlough and trip were obtained through application to Lovell.

It was not Alexis who thwarted the doctor's plan this time, but the outbreak of the Black Hawk Indian War. Beaumont's leave was cancelled and he and his regiment were directed to Fort Dearborn in Michigan. Other troops were being brought from the East by boat. The hostile Indians were soon routed with little loss of life through combat. However, word of a single case of Asiatic cholera caused mass desertions among the soldiers who, in their flight, spread the disease throughout the Middle West, with loss of life from the epidemic far exceeding combat mortalities. Beaumont had occasion to treat many of the stricken and noted:

/"The Greater proportional numbers of deaths in the cholera epidemics are, in my opinion, caused more by fright and presentiment of death than from the fatal tendency of violence of the disease . . ."/W.B.

In the summer of 1832 the doctor was again granted a furlough to carry out his postponed plans, but for only six months. He set out immediately for Plattsburgh and, hopefully, to reconnoiter with Alexis. And the young man did not disappoint him. To ensure the boy's presence for a full year, however, Beaumont caused to have drawn up a most unusual legal document.

/". . . the said Alexis shall . . . serve, abide and continue with the said William Beaumont, whereever he shall go or travel or reside in any part of the world and according to the utmost of his power, skill and knowledge, exercise and employ himself in and do and perform such service and business matters and things . . . as the said William shall . . . or do, direct and appoint . . ."/

In return, the doctor was to provide his "servant" with food, clothing, lodging and $150.00. The document (now in the library of Washington University Medical School in St. Louis) bears the signature of Beaumont and the X of St. Martin.

Many reasons are postulated for Dr. Beaumont's travelling to Washington, D.C. rather than to Europe (though his briefer furlough would seem to be explanation enough) and Washington seems to have been a most productive alternative. There were countless books and eminent minds for him to consult. And Lovell, as usual, rendered him every assistance including making Alexis a sergeant in the Army with a small stipend, clothing allowance and subsistence. This enlistment was a source of financial relief since Alexis was gradually becoming aware of his unique value to science and had continually increased his demands on his patron.

". . . the said Alexis shall . . . serve, abide and continue with the said William Beaumont. . ."

While conducting his third series of experiments, Beaumont was able to consult with Robley Dunglison, professor of physiology and chairman of the medical department at the University of Virginia, via an extensive correspondence and in person, when the professor visited Washington for the express purpose of meeting Beaumont and exchanging their respective speculations and observations on the chemical composition of the gastric fluids, and possible areas for further experimentation. Here were carried out the third series of observations and conclusions involving the solvent action of gastric juice, the importance of chewing action in spite of solvents and the relation of temperature to digestion.

PROFITABLE SIX MONTHS

A highly profitable six months elapsed. Once again Lovell offered assistance by assigning him to New York to examine recruits, a task which would leave him sufficient freedom to continue his experiments and to gather his conclusions into a form for publication. Before leaving Washington, he left Dunglison a vial of gastric fluid for his further analysis and the promise that he would continue to exchange pertinent findings.

Eager to gather all possible information on the chemical changes he had observed for inclusion in his book, Beaumont made a trip to New Haven where he was warmly received at the hands of Benjamin Silliman, then professor of chemistry and natural history. Silliman not only agreed to undertake an analysis of the fluid but also to enlist the interest and talents of Professor Jacob Berzelius of Stockholm in making similar tests.

/". . . My motive for troubling you with this affair is that I am anxious that a subject of such deep interest to mankind should be investigated by (pardon me for saying) the man of all others best qualified for the task . . ."/Silliman to Berzelius, 1833.

Concerning his progress in New York, however, Beaumont was less than content and wrote Lovell:

/". . . My official duties are very light and would not interfere at all with my experiments, could I avoid the vexatious official intercourse to which I am perpetually exposed in this City. It is an unfavorable place for the pursuit of physiological inquiries and experiments."/W.B., 1833

The Surgeon General, convinced of the value to mankind and to medicine of publishing Beaumont's work, once again transferred the doctor, this time to Plattsburgh where, though his title

was recruiting officer, he would have time to compile his results and put them in form for publication. This he did with the assistance of his cousin, Samuel Beaumont, who was not only a practicing physician but also conversant with details of publishing. The post in Plattsburgh also made possible a reunion with his family.

Alexis, on learning of the death of one of his children, left for a brief trip to Canada once more. There was little doubt of his return since he was still subject to army discipline. And Beaumont would have little need for his services as he was deeply immersed in the collating of material and the minutiae attendant to publication.

MANUSCRIPT COMPLETED

During the summer the manuscript of *Observations and Experiments on the Gastric Juice and the Physiology of Digestion* was virtually completed, to be sold by subscription. Notices including the table of contents and a description of the book (bound in pasteboard, three engravings and price: $3.00) were issued, but Beaumont delayed publication, ever hopeful that one of the two eminent chemists he had consulted would be able to isolate the solvent in gastric fluid which still escaped identification. He received lengthy and encouraging communications from Silliman, though the professor had been forced to delay experimentation owing to departmental demands and, indeed, provided disappointingly little new information, only confirming certain earlier statements about the presence of free hydrochloric acid when he did complete his analysis of the fluid. From Berzelius, there was no word. Beaumont continued from July until November with his fourth series of experiments with Alexis who had returned promptly.

Though no further information could be included in the book, Beaumont continued to be persistent in his quest and, hoping to avoid future interruption, executed a new two-year contract with St. Martin at a greatly advanced figure. The two devoted a brief period to appearances before medical societies and departments in the Northwest and then Beaumont released his partner once again for another short furlough.

". . . I have . . . a reputation far above my deserts. . ."



Thousands of Michigan tourists this summer will visit the William Beaumont Memorial, on Mackinac Island, where the young St. Martin was shot, giving Doctor Beaumont the opportunity to make his history-making gastric experiments.

When the book was published, it received wide and complimentary notices but the sales were disappointing. The doctor repaired to Washington once more, this time to appeal to Congress for an appropriation to cover the ever-growing expenses incurred in the support of Alexis and in the advancement of science. In spite of expert testimony in his behalf on the part of both political and medical lobbyists, the bill, involving about $4,000, was turned down by a vote of 129 to 56.

Disappointment piled on disappointment for, on Beaumont's return to Plattsburgh, Alexis had not returned or sent any word of his plans. Meanwhile, the harassed doctor had received orders to proceed to Jefferson Barracks, Missouri.

Once at his post, he tried through every available channel to get Alexis to rejoin him. Letters passed between the two, with the Canadian citing illness, the frozen and impassable waterways, the fact that he had just cultivated his garden, among his many excuses for remaining in Berthier. Beaumont appealed again to Morrison of the fur company:

/". . . I am desirous of ascertaining Alexis' situation and true disposition, and can only expect to succeed indirectly through your kindness and candor. Long, vexatious experience has too much impaired my confidence in him to rely upon his assertions and promises . . . I advanced him money, considerably more than was then due him . . . since which I have not seen or recd. anything from him but mere pretexts for his failure to return according to agreement . . ."/

A transfer to the arsenal at St. Louis was the doctor's final and permanent assignment. Reunited with his family, Beaumont settled in the city of St. Louis. Part of his time was occupied by his duties as attendant physician to the officers and their families stationed at the arsenal. As before, Surgeon General Lovell agreed to his pursuing a practice within the city and its suburbs, the practice no doubt enhanced by the reception accorded his book and the word of his experiments on the still-absent Alexis.

/". . . I have a very handsome, lucrative and respectable private practice . . . a reputation far above my deserts and a professional popularity more than commensurate with my best practical skill or abilities . . ."/W.B., 1834

Letters from Alexis and other interested parties and stories of the man's whereabouts continued to filter into the surgeon's St. Louis office. There were reports that he was prepared to return to the doctor's service if he could bring his wife and if the doctor would advance him some money. Other reports told of his addiction to drink ("an abandoned drunkard" wrote one) and of the family's utter destitution. Friends warned Beaumont that St. Martin would squander any sums advanced him for travel, but the frustrated man never ceased in his efforts. As late as 1852 — six months before the doctor's death — a final appeal went out to the wily Canadian.

/". . . Without reference to past efforts and disappointments . . . I now proffer to you in faith and sincerity, new, and I hope satisfactory, terms and conditions to ensure your prompt and faithful compliance with my most fervent desire to have you again with me . . . you know what I have done for you many years since . . . what efforts, anxieties, anticipations and disappointments I have suffered from your non-fulfilment of my expectations. Don't disappoint me more . . ."/W.B.

The two never met again.

Beaumont's practice and his reputation in St. Louis continued to increase. In 1835 when St. Louis University decided to establish a medical school, the doctor was approached to take the chair in surgery. Still attached to the Army, he accepted only provisionally, pending departmental consent. Unfortunately for Beaumont, his friend Lovell died in 1836 and was replaced by Thomas Lawson. Lawson, who was, in other respects, a fine surgeon general, seems to have been piqued by the many privileges accorded Beaumont by Lovell and it was rumored he planned to send the doctor to Jefferson Barracks. Through the intercession of friends, in military and political circles, this move was delayed and then dropped, but Lawson did, in fact, order his removal to Fort Brooks in Florida. The doctor reflected on his many years of service, his advanced age and the very happy life he had established for his family and himself in St. Louis and tendered his resignation unless the order to Florida were rescinded. After 25 years of devoted association, he was both indignant and deeply hurt by the peremptory acceptance of his separation, as were others:

/". . . The policy of the department has driven the best surgeon out of the army without the slightest occasion. I am sorry to lose you from the same profession in which I serve for the double reason of personal friendship and professional pride . . . a better physician or better man is not found in any country . . ."/Major Ethan Allan Hitchcock to W.B., 1839

Beaumont was now free to accept the University's offer, but the plans were slow in materializing and there is no record of his having actually lectured there, though a building opened in 1842 and there is evidence that he had planned to give a lecture course in digestion in 1851 using St. Martin as his laboratory exhibit.

PRACTICE HIS LIFE

Until his death, St. Louis was his home and practice was his life. And a lucrative practice it was, permitting Beaumont to buy a large tract of land in the country. In 1849 when a cholera epidemic broke out in St. Louis, he was on constant call, day and night, because of his previous experience with the dread disease and because of his reputation for serving humanity — rich and poor alike.

He was returning from a house call one cold winter night in March of 1856 when he slipped on some icy stairs, suffering a fall and a resulting infection which caused his death the following month. Because of his tenacity in the pursuit of a cause which interested him, Beaumont had his champions and his detractors. One memorial endorsement was made by physiologist Victor C. Vaughan: "Every physician who prescribes for digestive disorders and every patient who is benefitted by such prescription owes gratitude to the memory of William Beaumont for the benefit of mankind." Beaumont virtually wrote his own epitaph in a sentence much-quoted from his book on observations when he said: "Truth like beauty when 'unadorned is adorned the most'; and in prosecuting these experiments and inquiries, I believe I have been guided by its light."

Alexis St. Martin, the youth given up for dead in 1822, lived to age 83, sired 17 children and died in Canada in 1880 — 24 years after the death of the doctor. Many interested medical figures, including Sir William Osler, requested the opportunity of making an autopsy. Osler even made a sizable financial offer to the family through their parish priest in an effort to obtain the stomach which he planned to give to the Army Medical Museum in Washington but he, with the others, was turned down. St. Martin's widow, to thwart the possibility of any interference, hid the body in the house for several days until it was quite decomposed and then ordered her husband's grave dug eight feet deep as insurance against future disinterment.

Scientific Articles Printed to Date

Each month *Michigan Medicine* prints selected outstanding scientific articles. To date, the following papers (with month, page number and author following) have been published:

JANUARY

Page 31, *"Lower Lung Field Tuberculosis,"* by Ma. Zenaida Fernandez, M.D., Zamboanga City, The Philippines, and Edward G. Nedwicki, M.D., Allen Park.

Page 36, *"Use of Cholesterol Kits,"* by Kenneth R. Wilcox, M.D., (Reprint from New England Journal of Medicine, Vol. 279, No. 18).

Page 37, *"Mammography and Xeroradiography,"* by John N. Wolfe, M.D., Detroit.

Page 39, *"Early Management of Facial Nerve Trauma,"* by Roger Boles, M.D., Ann Arbor.

Page 45, *"Treatment of Hypercalcemia,"* by Joseph J. Weiss, M.D., and Jose Yanez, M.D., both of Eloise.

Page 49, *"More Drugs Mean More Problems in Managing Diabetes Mellitus,"* by John B. Bryan, M.D., F.A.C.P., Royal Oak.

FEBRUARY

Page 119, *"The Future of Private Practice: Salvation at the Grassroots;"* by Lewis A. Miller, Stamford, Conn.

Page 131, *"Mouse Toxicity of Triple Vaccine (DTP) Mixed with Poliomyelitis Vaccine,"* R. Y. Gottshall, G. R. Anderson, E. A. Nelson and K. R. Wilcox, M.D., all of Lansing.

Page 135, *"Massive Intra-articular Injection of Methylprednisolone without Harmful Side Effect,"* by J. C. Breneman, M.D., Galesburg.

MARCH

Page 209, *"Myocardial Infarction During Hyperthyroidism,"* by Robert C. Douglass, M.D., Southfield; Myer Teitelbaum, M.D., Detroit, and Gerald J. Aben, M.D., Southfield.

Page 213, *"Trichophyton Violaceum,"* by James D. Stroud, M.D.; Jules Altman, M.D., and Coleman Mopper, M.D., all of Detroit.

Page 215, *"Psychiatric Referral of a Pediatric Patient,"* by Joan R. Chodorkoff, Ph.D., and Bernard Chodorkoff, M.D., Ph.D., both of Detroit.

Page 217, *"Development of a Program of Laryngoscopy, Therapeutic Bronchoscopy and Endobronchial Blocking Techniques: A Progress Report,"* by Martin L. Norton, M.D., F.A.C.C.P., Detroit.

Page 220, *"Accidental Poisoning, Where Do We Go From Here?"* by George M. Lowrey, M.D.

Page 221, *"Diabetes and Pregnancy — Preliminary Report,"* by Nancy T. Caputo, M.D., and Agna N. Pineda, M.D., both of Detroit.

Page 223, *"The Electrophoresis of Lipoproteins,"* by John G. Batsakis, M.D., and Martha M. Thiessen, B.S. (ASCP), both of Ann Arbor.

APRIL

Page 341, *"Suprapubic Cystostomy In Gynecologic Surgery,"* by Morton R. Lazar, M.D., F.A.C.S., F.A.C.O.G., and Eugene A. Snider, M.D., both of Detroit.

Page 345, *"Rhabdomyosarcoma: Report of 20 Cases,"* by Lawrence S. Bizer, M.D., Detroit.

Page 349, *"Psychiatric Referrals In A General Hospital,"* by Wiecher H. Van Houten, M.D., Ann Arbor.

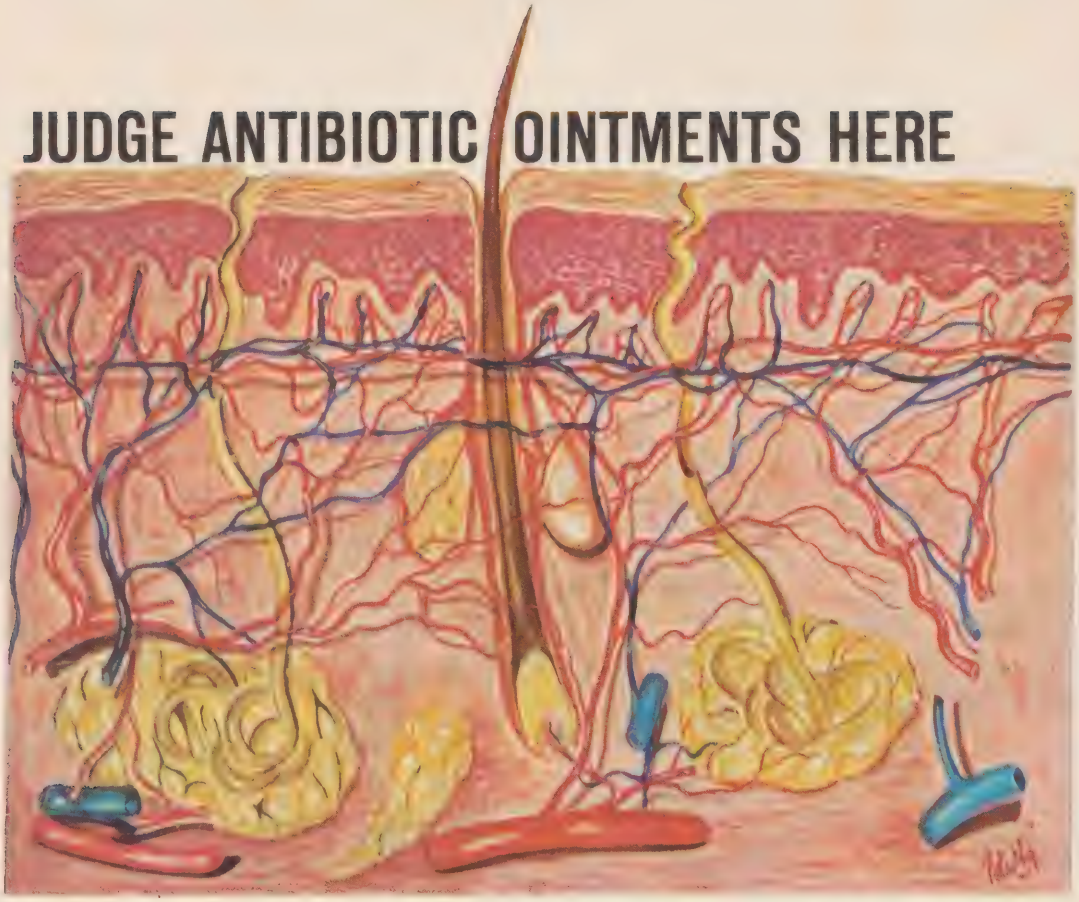
Page 353, *"The Sinai Hospital Low Vision Clinic,"* by Morris J. Mintz, M.D., Ernest M. Gaynes, O.D., and Arnold H. Gordon, O.D., all of Detroit.

Page 357, *"The Physician and Differential Diagnosis of Communicative Disorders in Children,"* by Gerald S. Light, M.D., and William Wolski, Ph.D., both of Flint.

MAY

The issue featured special Michigan Week articles by leaders in health care in Michigan.

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Mild ulcerative colitis may be triggered here...



or here.



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and toler-. Though generally not recommended, if bination therapy with other psychotropics is indicated, carefully consider individual macologic effects, particularly in use of poating drugs such as MAO inhibitors and othiazines. Observe usual precautions in ence of impaired renal or hepatic function. doxical reactions (*e.g.*, excitement, stimulaand acute rage) have been reported in psyric patients. Employ usual precautions in ment of anxiety states with evidence of imling depression; suicidal tendencies may be nt and protective measures necessary. Vari- effects on blood coagulation have been ied very rarely in patients receiving the and oral anticoagulants; causal relationhas not been established clinically.

ADVERSE REACTIONS: No side effects or ifestations not seen with either compound have been reported with Librax. When diazepoxide hydrochloride is used alone, siness, ataxia and confusion may occur, cially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics, and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS

MSMS Members In the News

James F. Dooley, M.D., Grand Blanc,
is new president-elect of the Michigan State Academy of General Practice. A Flint private practitioner, Doctor Dooley was elected next-in-line to MAGP President Douglas A. Haddock, M.D., Kalamazoo.

Dan W. Myers, M.D., Detroit,
has been appointed Grace Hospital's first full-time chief of the division of medicine by the hospital's board of trustees.

E. J. Dudzinski, M.D., New Baltimore,
who has retired after 35 years of private practice to become medical director at Martha T. Berry Hospital in Macomb County, was recently honored by 250 of his townspeople at a community-wide dinner, followed by a country club reception. The New Baltimore City Council also passed a resolution expressing "a sincere, grateful and heartfelt thank you to our Doctor Dudzinski."

Harry A. Paysner, M.D., Highland Park,
was launched into retirement recently at a dinner in Warren attended by 300 of his patients. Doctor Paysner, 70, has practiced more than 40 years and served several generations.

C. A. Peterson, M.D., Hillsdale,
has accepted a new position in the Canal Zone, Panama. Doctor Peterson, who has been a member of the Committee on Medicine and Osteopathy, left the US May 30 to become a staff physician with the hospitals of the Panama Canal Company.

John Dorsey, M.D., Birmingham,
chairman of the MSMS Committee on Child Welfare, was among the speakers at a Forum on Fair Housing sponsored recently at the Grosse Pointe Unitarian Church. Doctor Dorsey was earlier the chairman of the successful effort to achieve a local Fair Housing Ordinance in Birmingham.

A new room
in the music therapy department of Wayne County General Hospital was dedicated recently in memory of the late Ira M. Altshuler, M.D., killed in an auto accident in Livonia in March, 1968. Doctor Altshuler was internationally known for his development of music therapy for the mentally ill. He had retired in 1963 at the age of 70, but maintained his private practice of psychiatry until his death.

Ignatious J. Voudoukis, M.D., Detroit,
has been named to the Clinical Laboratory Facilities Council, a new advisory group to the Michigan State Department of Public Health. Doctor Voudoukis, an internist specializing in the treatment of hypertension, is affiliated with Grace and Hutzel Hospitals in Detroit. The Council's major responsibility is the establishing of rules for setting up standards for licensing Michigan laboratories.

William W. Nicholls, M.D., Flint,
is serving a one-year term as president of the Flint Academy of Medicine. He succeeded Paul E. Schroeder, M.D., and is also chief of the Department of Pediatric Medicine at the C. S. Mott Children's Health Center in Flint.

Walter P. Work, M.D., Ann Arbor,
is vice president of the new American Council of Otolaryngology, incorporated recently in the District of Columbia to represent the patient care interests of the nation's estimated 6,000 otorhinolaryngologists.

Mark C. Levine, M.D., Flint,
has received academic appointment as assistant clinical professor of medicine in Michigan State University's College of Human Medicine.

Frank V. Hodges, M.D., Flint,
presented a paper titled, "Diffuse Amyloidosis of the Respiratory Tract" at the meeting of the College of American Pathologists and the American Society of Clinical Pathologists held recently in Los Angeles.

Douglas A. Haddock, Jr., M.D., Kalamazoo,
was elected president of the Michigan Academy of General Practice at the academy's general meeting recently in Detroit.

Robert R. Dew, M.D., Kalamazoo,
has been selected by the American Academy of Pediatrics to serve as a Head Start consultant in Michigan.

Ray O. Creager, M.D., Kalamazoo,
was chairman of a symposium on brain dysfunction at the annual meeting of the American Orthopsychiatric Association held recently in New York City.

Three Kalamazoo physicians
were recently elected fellows of the American College of Physicians. They are Daniel K. Christian, M.D.; Raymond M. DeHaan, M.D., and Roger Morrell, M.D.

James T. Howell, M.D., Birmingham,
hospital consultant, will address the question "Why Does the Practicing Physician Have to Be More Effectively Integrated Into Hospital Management?" during one of the general sessions of The Evolving Health Care System conference June 10-13 in Minneapolis sponsored by the Catholic Hospital Association.

Clarence S. Livingood, M.D., Detroit,
has been elected president of the American Dermatological Association. Doctor Livingood is chairman of the Department of Dermatology at Henry Ford Hospital.

William J. Jones, M.D., Detroit,
was elected president of the City Council of Allen Park. Doctor Jones is also a member of the Board of Directors of the National Health Foundation.


It takes more than a pill
to lose weight

That's why Abbott's got what it takes–
a pill and a program for each patient

THE PRODUCT–5 Different Strengths

For smooth appetite control plus mood elevation

Desoxyn® Gradumet®

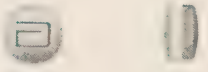
Methamphetamine Hydrochloride in Long-Release Dose Form



For patients who can't take plain amphetamine

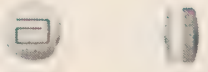
Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride, 60 mg. Sodium Pentobarbital



Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride, 90 mg. Sodium Pentobarbital



THE PROGRAM–3 Patient Booklets



Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably —and permanently. Food exchanges and a comprehensive list of foods, showing their calories, are also included.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

Compact new booklet features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

902110

ABBOTT

Please see Brief Summary on next page.

Ask Your Abbott Man For Patient Supplies.

BRIEF SUMMARY

Desoxyn® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

Desbutal® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

Desbutal 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates, or in those with history of manifest or latent porphyria.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Because of its sodium pentobarbital content, use Desbutal with caution in patients receiving coumarin anticoagulants. Pentobarbital may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

902110

ABBOTT

Richard Torpin, M.D., Augusta, Ga., and Roman R. Knoblich, M.D., Flint, "Fetal Malformations of Amniogenic Origin," page 126, *Journal of the Georgia Medical Association,* March, 1969.

Steven A. Myers, M.D., and Donald F. Caldwell, Ph.D., Detroit, "The Effects of Marihuana on Auditory and Visual Sensation: A Preliminary Report," page 212, *The New Physician,* March, 1969.

Richard C. Bates, M.D., Lansing, "Let's Pay Doctors to Keep People Well," page 100, *Medical Economics,* March 31, 1969.

Richard C. Bates, M.D., Lansing, "Resolving Patient Gripes About Time," page 214, *Medical Economics,* April 14, 1969.

Marshall Nathan, M.D., and John G. Batsakis, M.D., Ann Arbor, "Congenital Hepatic Fibrosis," page 1033, *Surgery, Gynecology and Obstetrics,* May, 1969.

Jorge O. Just-Viera, M.D., San Juan, Puerto Rico, and Camero Haight, M.D., F.A.C.S., Ann Arbor, "Achalasia and Carcinoma of the Esophagus," page 1081, *Surgery, Gynecology and Obstetrics,* May, 1969.

W. J. Mattson, Jr., M.D., and J. G. Turcotte, M.D., F.A.C.S., Ann Arbor, "Survival and Metabolism in Experimental Endogenous Hepatic Coma," p. 557, *Surgery — Gynecology and Obstetrics,* March, 1969.

Gerald P. Hodge and James G. Ravin, M.D., Ann Arbor, "Spanish Art — A Contribution to Medicine," page 1693, *Journal of the American Medical Association,* March 3, 1969.

Edwin L. Harmon, M.D., and Amalia Krause, R.N., Lansing, "Blue Cross Home Care Benefits: The Michigan Experience," page 70, *Hospitals,* March 1, 1969.

Richard C. Bates, M.D., Lansing, "Games Doctors and Patients Play," page 98, *Medical Economics,* March 17, 1969.

MSMS Highlights 25 Years Ago

— **C. R. Keyport, M.D., was the MSMS President for 1943-44**

— **2,175 Michigan doctors were serving in World War II**

— **MSMS made its first use of radio, with a 13-week series over 12 stations**

— **MSMS and its Auxiliary contributed toward the efforts to defeat pending Wagner-Murray-Dingell Bill**

— **A Century of Service in Medicine By William J. Stapleton, Jr., M.D. Published by MSMS, 1955**

Two good reasons to specify LEDERCILLIN® VK

Potassium Phenoxymethyl Penicillin

1. It's a Lederle product.
2. Low price.

Tablets:
250 mg—100's and 1000's
For Oral Solution:
125 mg/5 cc—80 cc and 150 cc
250 mg/5 cc—80 cc and 150 cc

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

9-7-1041/461-9

NEW



LEGAL

ALIENATION OF AFFECTIONS SUIT AGAINST PHYSICIAN DISMISSED

(From the AMA Citation newsletter of Feb. 1, 1969.)

A husband's suit against a physician for having allegedly induced his wife to become intimate and procure a divorce, while purporting to act as a marriage counselor to the couple, was properly dismissed for failure to state a cause of action, a Michigan appellate court ruled. Although the complaint was in terms of breach of contract and fraud, it stated causes of action for either alienation of affections or criminal conversation, both of which have been abolished by statute.

While being treated for an injury, the husband told the physician about the marital difficulties that he was experiencing. The husband alleged that the physician offered to reconcile his marital problems through the use of psychiatry and other means and warranted that his marital relations would improve. The couple consulted the physician for more than a year. Shortly after the consultations ceased, the wife obtained a divorce.

Two years later the husband saw his ex-wife's record from a state hospital, in which it was stated that she had told her physicians there that she had been intimate with the physician. She later told the husband that her personal relationship with the physician had begun at almost the start of the consultations and had continued for more than a year after the divorce.

The husband alleged that the physician had breached a special agreement to reconcile his marital problems through the use of psychiatry and other means, in that he failed to constructively counsel the couple, failed to use psychiatry, and induced the wife to become intimate with him and to procure a divorce.

Although a physician and his patient may enter into an express contract for psychiatric services containing a warranty of cure, it must clearly appear from what was said by the parties at the time of the making that this is what was intended. There was no such intention shown here.

Further, whether a cause of action is one in contract or one in tort depends, not on the form in which it is alleged, but on the essential facts or grievance alleged. The gist of an action for alienation of affections was a husband's loss of his wife's society, services, and comfort by means of the tortious conduct of the person against whom the suit was brought. The gist of an action for criminal conversation was an actual marriage plus adulterous intercourse. The action for alienation of affections necessarily involved intent to induce the spouse to separate, and malice was conclusively presumed in the case of adultery. The allegations of the contract cause of action actually stated causes of action for alienation of affections and criminal conversation. Both of those causes of action have been abolished by statute.

The fraud cause of action was also subject to the objection that it actually stated causes of action for alienation of affections and criminal conversation. — *Nicholson* v. *Han*, 162 N.W.2d 313 (Mich., June 25, 1968)

from Vol. 18, No. 8

APPOINTMENT OF ACTING MEDICAL EXAMINER; "REINSTATEMENT" REFUSED

(Editor's Note: The following articles are quoted from the **AMA Citation** *newsletter of March 15, 1969, prepared by the AMA Law Department.)*

A physician's petition for an order requiring the county board of supervisors to "reappoint" her as acting medical examiner for the county was properly refused by the trial court, a Michigan appellate court ruled. Her "appointment" as acting medical examiner was not in accordance with prescribed statutory procedures. Since there had been no valid appointment, reinstatement procedures were inapplicable.

After the death of the county medical examiner, the clerk of the medical examiner committee of the county board of supervisors notified the physician that she had been named acting medical examiner for the county. The board subsequently directed the medical examiner committee to hold a hearing to review qualified applicants so that it could make a recommendation to the board as to a temporary appointment to the post of medical examiner.

After a hearing, at which the physician was not present, the committee recommended another person for the post of acting medical examiner. A second hearing was held, at which the physician appeared and was heard. At the close of that hearing, the committee recommended the same person for the post that it had after its first hearing. The board appointed as acting medical examiner the

person recommended by the committee as the result of its hearing.

The statute provides that the head of a department may fill a position in competitive civil service for 60 days or less pending a regular appointment to the position. The head of the department in this case was the full board of county supervisors. The board never acted as a body to appoint the physician to the temporary position. Therefore, in the absence of an appointment and a removal from the position, "reinstatement" was inapplicable. In addition, she could not complain of anything that may have occurred at the hearings, because the board was not required by statute to hold them. —*Raven* v. *Wayne County Board of Supervisors,* 162 N.W.2d 897 (Mich., July 24, 1968).

from Vol. 18, No. 11.

TREATMENT NOT INTERVENING CAUSE OF DEATH

In a prosecution for negligent homicide by operation of an automobile, the jury was properly instructed that it was not to consider whether there was any negligence on the part of the physicians and nurses who treated the victim which could be termed an intervening cause of death, a Michigan appellate court ruled. There was no evidence of any negligence in the medical treatment.

The accused's car collided with a school bus on which the 6-year-old victim was a passenger. The bus driver testified that the victim said immediately after the accident that the back of her neck hurt and pointed out a small red mark on her neck.

A registered nurse who checked the children for first aid at the scene of the accident did not remember the victim. Nor did a physician who examined her shortly after the accident specifically remember her.

When the bus driver took the victim home at noon, the driver told her parents about the victim's bruise and the physician's examination. The child was then complaining of a pain in the back of her neck and had a large goose egg on her neck behind her left ear. Late in the afternoon she began to vomit and suffer severe head pain. Her parents took her to the hospital.

At the hospital, X-rays were taken. The neurologist who treated the victim said that, since the X-rays showed no abnormality, he concluded that the victim probably had the flu. However, he kept her in the hospital overnight. When the neurologist came to the hospital the next morning, he was told that the victim had suffered a strange spell a short time before, in which she had stiffened, but that it had lasted only a short time and she had resumed her more or less sleepy attitude. There had been no change in her blood pressure, pulse, temperature or anything else.

While the neurologist was discussing the victim's case at her bedside with five other physicians, she suddenly stiffened out and stopped breathing. Attempts to resuscitate her were unsuccessful. An autopsy disclosed that she had had a large epidural hemorrhage. The hemorrhage was caused by two small fractures at the base of the skull.

There was nothing in the record showing negligence on the part of any physician or nurse who examined or treated the victim. Thus, the trial court properly instructed the jury not to consider the question of whether negligent treatment was an intervening cause of death.—*People of the State of Michigan* v. *Jones,* 163 N.W.2d 266 (Mich., Aug. 26, 1968)

NEW GUIDE RELEASED FOR HOSPITAL PRESS RELATIONS

In a joint effort the Michigan Hospital Association and the Michigan Press Association have issued a recommended guide to better hospital-press relations.

The purpose of the guide is to promote cooperative action between Michigan hospitals and the commercial news media in their service area.

"The guide stems from the conviction that hospitals are becoming increasingly important sources of health news in their communities and that news media representatives need accurate and prompt sources of information to fulfill their responsibility to keep the public informed of all matters affecting their lives, health and pocketbook," said the two associations in a joint statement printed on the guide.

The guide defines, for working purposes, good, fair, serious and critical conditions; the hospital spokesman; exclusives and cases of public record. It lists items of public information in cases of public record and describes procedures to follow in obtaining pictures.

In the same spirit the University of Michigan Health Center has produced a policy guide on photographing patients that attempts to define the matter and indicate the center's goals and limitations. The three-part U-M guide lists photo categories, guidelines for taking pictures and obtaining releases and clarifies authority.

Copies of the guide may be obtained from MSMS.



SOCIO-ECONOMIC

"Real Issues" In Next Election Of State Supreme Court

BY ELMER WHITE, EXECUTIVE DIRECTOR
MICHIGAN PRESS ASSOCIATION

Next year's state Supreme Court elections will determine if the Democrats or Republicans benefit from legislative redistricting in 1971.

That's the prediction of Justice Eugene F. Black, who is not up for re-election.

Presently the court is comprised of four Democrats and three Republicans, though members are technically elected on a nonpartisan basis. The terms of two GOP members expire in 1971.

Black predicted the court will ultimately redistrict the legislature because of a deadlock within the apportionment commission following the 1970 federal population census.

* * *

"We are apt to see a partisan-divided Supreme Court deciding in 1971 whether the Legislature shall be elected for the next 10 years according to a strictly one-sided Democratic plan, or a strictly one-sided Republican plan of legislative apportionment," Black said.

The Justice proposed the Legislature change procedures for nominating court candidates at party conventions, and make the selection process purely nonpartisan.

* * *

As an alternative, he suggested the parties nominate candidates "willing to commit themselves to an open presentation" of their views on criminal justice and other key issues.

"Michigan needs such a Supreme Court contest," Black said. "We then could have a campaign turning upon a really genuine as well as publicly critical issue."

Doctor's Tax Calendar Through December, '69

JULY 1 — File a renewal application for your federal narcotics tax stamp. Include an inventory of narcotics on hand. Mail these, together with a check for $1, to your District Director of Internal Revenue.

JULY 15 — If your contributions to your employes' Social Security plus the Social Security and income taxes *withheld* from their salaries exceeded $100 in June, complete Form 501 and pay the taxes.

JULY 31 — Pay the balance of your second-quarter contributions to your employes' Social Security, plus Social Security and income taxes *withheld* from their salaries from April 1 through June 30. File Form 941.

AUG. 15 — If your contributions to your employes' Social Security plus the Social Security and income taxes *withheld* from their salaries exceeded $100 in July, complete Form 501 and pay the taxes.

SEPT. 15 — Pay the third insallment of your 1969 Federal tax (one-fourth of your estimated income tax and one-fourth of your 1969 Social Security tax). If your taxable income so far this year varies 10 percent or more from your last estimate, it's advisable to file an amended 1040-ES. (Use the quarterly payment form you received.)

If your contributions to your employes' Social Security plus the Social Security and income taxes *withheld* from their salaries exceeded $100 in August, complete Form 501 and pay the taxes.

OCT. 15 — If your contributions to your employes' Social Security plus the Social Security and income taxes *withheld* from their salaries exceeded $100 in September, complete Form 501 and pay the taxes.

OCT. 31 — Pay the balance of your third-quarter contributions to your employes' Social Security, plus the Social Security and income taxes *withheld* from their salaries from July 1 through Sept. 30. File Form 941.

NOV. 17 — If your contributions to your employes' Social Security plus the Social Security and income taxes *withheld* from their salaries exceeded $100 in October, complete Form 501 and pay the taxes.

DEC. 15 — If your contributions to your employes' Social Security plus the Social Security and income taxes *withheld* from their salaries exceeded $100 in November, complete Form 501 and pay the taxes.

Mail to: Medicare, Medicaid Question Department
c/o Michigan State Medical Society
120 W. Saginaw
East Lansing, Michigan 48823

My question is: _____

_____

Name _____

Address _____

Medicare, Medicaid Queries To Be Answered

Questions have begun coming to MSMS headquarters regarding Medicare and Medicaid after *Michigan Medicine* initiated a "What Is Your Question?" section recently on the policies, procedures and difficulties of the two health care plans.

A questionnaire first appeared in the April issue to be filled out and mailed to the Medicaid, Medicare Question Department. A second such questionnaire is printed above for clipping and mailing.

If sufficient inquiries are received it is hoped that other medical programs and subjects can be included for response by MSMS staff. Initially, only general questions can be accepted and individual problems about correctness of reimbursed fees are to be directed to Michigan Medical Service.

MSMS hopes you will detach the following form, fill it out and mail it in, and by this innovation stimulate and expand your interest and knowledge in every area of your concern.

DOCTORS TO HELP PAY $9,374,400,000 MICHIGAN TAX BILL

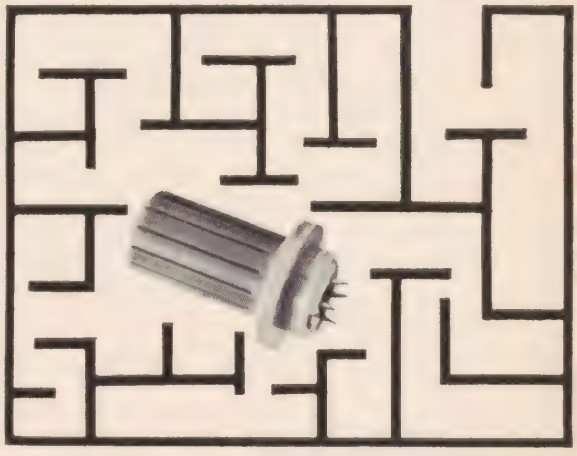
Michigan doctors will contribute to the approximately $9,374,400,000 Michigan taxpayers will be required to pay this year to support the Federal spending budget of $195.3 billion proposed by former President Johnson for the fiscal year beginning Jan. 1.

Harry R. Hall, president of the Michigan State Chamber of Commerce, made the estimate of Michigan taxpayers share according to the Chamber's calculations that Michigan residents bear 4.80% of all Federal taxes. That percentage is derived from a formula developed by the Tax Foundation, the U.S. Chamber of Commerce and the Council of State Chambers.

The money paid by Michigan citizens in federal taxes and the 4.80% share of the national budget is a good illustration of why state and local governments have great difficulty meeting expanding costs of services," said Mr. Hall.

FEDERAL FUNDS AID SCHOOLCHILDREN

A total of $9,726,869 will be received by Michigan from federal school food programs for food and milk. The State Board of Education reports the program this year will help feed 75,000 Michigan youngsters to ease "the battle between hunger pangs and learning." Last year programs aided 25,000 Michigan pupils.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9

The medical and religious professions are drawn together through their common concern for people and their combined roles in treating patients, particularly those that have a faith. So notes the AMA, and MSMS, which sponsored the annual MSMS Medicine and Religion Workshop last month at MSMS headquarters. In connection with the workshop, the following articles include a round-up of county society medicine-religion committee activities and ideas; a discussion by Winslow G. Fox, M.D., Ann Arbor, chairman of the MSMS Committee on Medicine and Religion, of the history and importance of the relationship between physicians and the clergy in Michigan, and excerpts from the workshop address of the Rev. Dr. Paul B. McCleave, AMA Medicine-Religion director. Photo highlights of the workshop will appear in the July issue of MICHIGAN MEDICINE.

"We Need to Work Together, Talk Together," Says MSMS Medicine-Religion Chairman

BY WINSLOW G. FOX, M.D., CHAIRMAN
MSMS COMMITTEE ON MEDICINE AND RELIGION

Soon after the AMA established the Department of Medicine and Religion in 1961, Michigan called Richard Rapport, M.D., of Flint to be its first chairman for Medicine and Religion. The goal, patterned after the AMA Department's aim was to foster in Michigan a climate for better communication between clergy and physicians, looking towards better care of the whole man.

How do you go about creating a "climate"? How can you bring together what is separate? Our formula has been simple — namely our common concern for people, who are parishoners to the clergyman and patients to the doctor. The men of these two professions — busy at the 60 to 80 hour work week that most of us put in, need to have some such simple, clear call to go to yet another meeting! This concern for the "Whole Man" has enabled clergymen and physicians to find the time to come together for increased understanding and support.

EACH YEAR, presidents of county medical societies receive from us via the East Lansing office a letter, which asks them to appoint a chairman for medicine and religion, and a committee to work with him. Nearly two-thirds of the county medical societies have responded to this call, and have committees in various stages of activity.

Part of the genius of this movement has been that it is locally directed and managed, in response to the needs of a particular situation. Generally the physicians approach clergy on an individual basis, then possibly through their professional association, to invite them to a dinner — or to a breakfast — followed by viewing the excellent A.M.A. films, "The One Who Heals" and "A Storm, A Strife." The stage is then set for meaningful discussion between the two groups on certain aspects of patient care, as highlighted by the film.



Winslow G. Fox, M.D., Ann Arbor, left, MSMS Medicine and Religion Committee Chairman, reviews activities of the committee with new committee member Charles T. Vear, M.D., Hillsdale.

Subsequently, there may be formal meetings, either regular or sporadic, but strangeness and reticence between doctor and clergy are being re-

placed by warmth and confidence. A man who may have been Rev. Pussyfoot to the doctor before, now becomes Rev. Compassion, and the physician is more likely to phone him when he runs into a sticky problem of goals, aimlessness, or anxiety in one of his patients.

The State Committee had the honor of planning the opening meeting of the M.S.M.S. Centennial in Sept., 1965. This outstanding event was attended by over 1,000 people, in Ford Auditorium in Detroit. Addresses were given by the Rev. Paul B. McCleave, LL.D., AMA, Chicago; Dr. Karl Menninger, president of Menninger Foundation, Topeka, Kansas, and The Rev. John Weaver, S.T.B., former Dean of Cathedral Church of St. Paul, Detroit.

In May of 1968, our state committee co-sponsored the Physician-Clergy Workshop of Alma College, on the topic, "The Pastor in the Sick Room — a Help or a Hindrance."

WHAT OF the future? We have hopes that every county medical society in Michigan will have an active committee devoted to creating this improved climate for communication between doctors and clergymen. Our patients are asking us questions, and our advancing technology is posing problems that were not faced 20 years ago. We need to work together, and talk together, to advance the care of the whole man.

An exciting new medium is at our disposal. For about two years the AMA Department of Medicine and Religion has been working to produce a new film. It is now released, and is titled, "A Storm, A Strife." It was my privilege to view this film at a recent Workshop in Chicago, sponsored by the Department of Medicine and Religion. It is a tremendous film. The high professional standard of the first such film, "The One Who Heals" has been maintained, and even advanced. County medical societies will soon be able to book this new film through staff assistant Ralph Wills, the M.S.M.S. office in East Lansing. It will provide a stimulating springboard along with other available material at MSMS headquarters, for further dialogue between physicians and clergy.

Across the country, the AMA Department of Medicine and Religion has been in contact with many theological seminaries. These training centers for clergymen have felt the need for greater contact with medicine, in these formative years. As a consequence of a catalytic role played by Doctor Paul McCleave and his co-workers, many doctors are now assisting in a faculty role in seminaries of several denominations.

WE IN Michigan hope to establish contact with our local seminaries in an attitude of helpfulness, seeking to answer questions and serve in whatever consultative role may be appropriate.

Report from the National Level

Making it possible for the two professions to become acquainted and inter-related in order to make total patient care more complete — that is the emphasis of the AMA's medicine and religion program and the message it tries to bring to its state and county component societies.

That is according to the Rev. Dr. Paul B. McCleave, Ll.D., Chicago, Director, AMA Department of Medicine and Religion, as he spoke at the annual MSMS Medicine and Religion Workshop May 8 in East Lansing.

The Rev. Dr. McCleave offered advice to county medicine and religion chairmen and their guests, mostly clergymen, on creating local programs to bring together the physicians and religious leaders of their communities.

"Every patient does not need a clergyman; neither does every parishioner need a doctor," said The Rev. Dr. McCleave. "But there are times when every family needs spiritual guidance.

"And if the doctor can turn to the clergyman in those times, then there is one more hand to help in the total care of the individual."

The Rev. Dr. McCleave counseled the doctors that once a program is undertaken it must be continued regularly, because of the high rate of



The Rev. Dr. McCleave

The keynote address at the workshop was delivered by William N. Hubbard, Jr., M.D., dean of the University of Michigan Medical School.

change of clergymen in a community (average stay in one spot: 3.3 years) and because a one-shot program will create the impression of insincerity.

The AMA on the national level, the Rev. Dr. McCleave informed the group, is helping to develop programs within seminaries acquainting future clergymen with hospitals and medical terminology and is approaching medical interns and residents with programs emphasizing the patient as a person, not a case.

Also on a national level, the AMA is attempting to create discussion and dialogue between distinguished men in the two professions on problems of society, reported the Rev. Dr. McCleave. He suggested that the state's schools of medicine organize medicine and religion seminars on the postgraduate level.

And he added that medicine has a tremendous responsibility today to "tell the ministry that the heart is not 'life, compassion, love' but just another organ."

County Societies Unite Doctors, Clergy In Variety of Activities, Discussions

BY JUDITH MARR
MANAGING EDITOR

The medicine and religion committees of county medical societies around the state find a variety of ways to bring the physicians and clergymen of their local communities together.

For instance, the Jackson County Medical Society's committee, chaired by Bruce Davenport, M.D., sponsors meetings over breakfast between small groups of medical and religious professionals of the area.

The Saginaw County Medicine and Religion Committee participated last year in presenting a series of conferences during a ministerial seminar at the area Veterans Administration Hospital.

COMMITTEE MEMBERS spoke of the emotional impact of cardiac disease, pregnancy and surgery on the family and the emotional needs of the alcoholic patient. "This was an out-going attempt at community relations and appeared to be successful," reported Robert J. Toteff, M.D., then committee chairman. The program was enthusiastically received both by the VA Hospital staff and members of the ministerial seminar.

In Ingham County, physicians invited clergymen to be guests for a special meeting when the speaker was ex-Congressman Walter Judd, M.D., of Minnesota, who had served as a medical missionary.

"We have found that more good is done when we simply talk with each other than when we have eminent speakers talk to us about the importance of getting together," observed Albert E. Heustis, M.D., Lansing, medicine-religion committee chairman for the Ingham County society.

The Ingham doctors also took advantage of nearby Michigan State University's recent "Colloquy on Sexuality" seminar to invite seminar speaker Alan F. Guttmacher, M.D., New York City, president of Planned Parenthood-World Population, to speak before a joint group of clergy and doctors.

In Midland, reports R. P. Grant, M.D., local medicine-religion chairman, doctors have sponsored two joint meetings in the past year, one at a local hospital and another featuring a talk by a guest minister who's also on the staff of the Chicago University Medical School.

"We've had a warming of relationships in Midland between the two professions and we're happy with that," says Doctor Grant.

The Kalamazoo Academy of Medicine is planning a doctor-clergy dinner Sept. 10 at Bronson Hospital, a common method used by county societies to bring the two professions together.

And showings of the AMA film, "The One Who Heals" have stimulated discussion among doctors and clergymen meeting together through still more county societies.

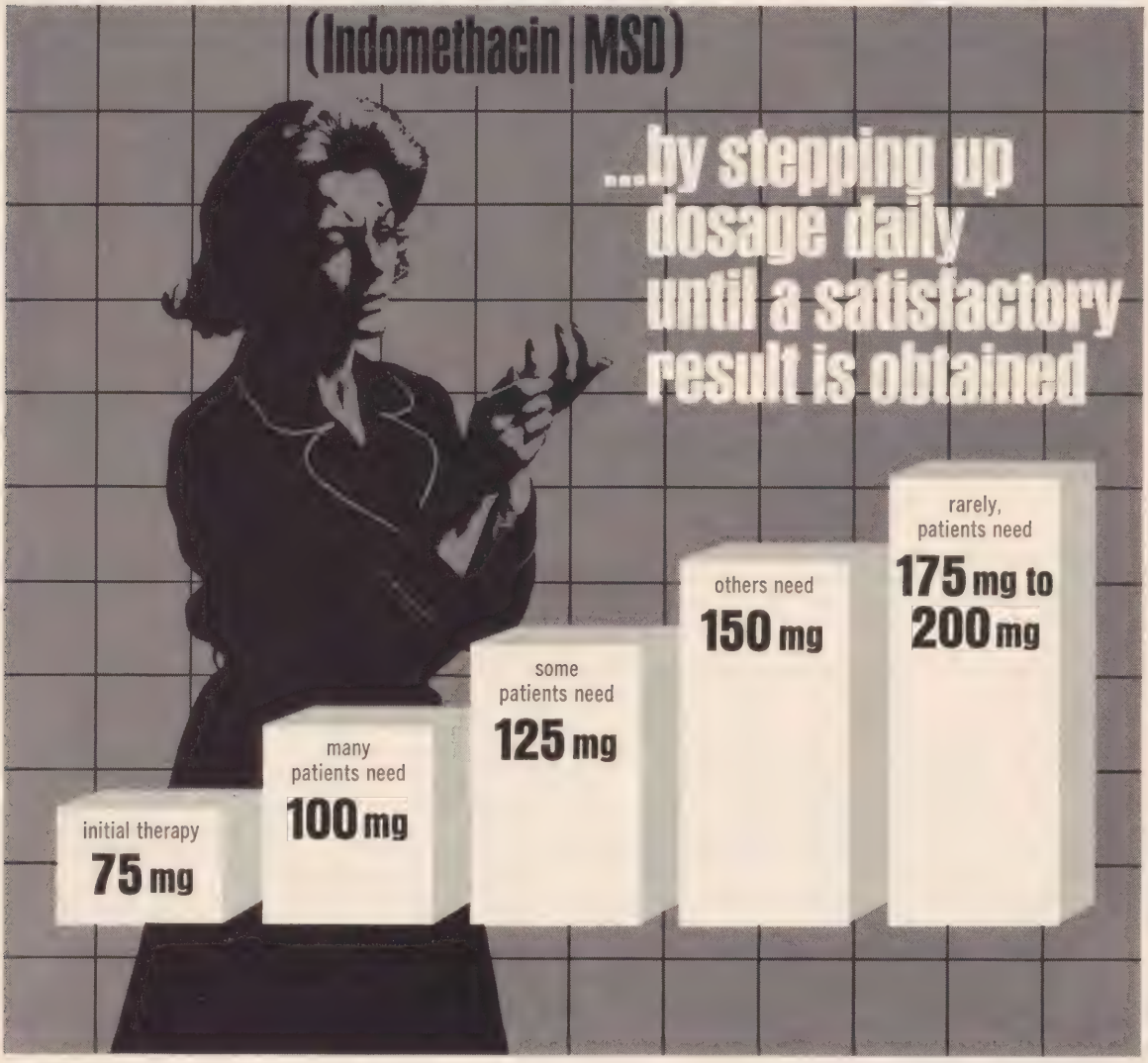
One such meeting was held recently by the Tuscola County Medical Society's medicine-religion committee, led by Maurice Chapin, M.D. Following the film the local clergymen were eager to discuss with his committee members such emergency family situations as the diagnosis of cancer, heart attacks, the death of a child or automobile accidents, which were detailed in the film. Doctors and ministers are eager to learn how they can better work together with the same "patients," reports Doctor Chapin, and to discover how the two professions handle the same problems.

From one such meeting, he says, came a joint wish to discuss the problems of the unwed mother.

(Continued on Page 610)

In selected cases of rheumatoid arthritis with acute symptoms

Response to INDOCIN® is often improved...



Many patients with acute rheumatoid arthritis or acute episodes of chronic rheumatoid arthritis can be controlled by increasing the dosage 25 mg *per day* (to the allowable maximum) until the episode subsides; the dosage should then be reduced gradually to maintenance levels. Few require the maximum (175–200 mg).

In the event the patient develops adverse effects, dosage should be reduced to tolerated levels for 2 or 3 days and then gradually increased by 25 mg every few days as tolerated. G.I. effects may be minimized by giving INDOCIN with food, antacids, or immediately after meals.

Now in two strengths
25 mg and 50 mg



Actual Size

INDOCIN®
(Indomethacin | MSD)

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under *Indications*. The drug should not be prescribed for children because safe conditions for use have not been established.

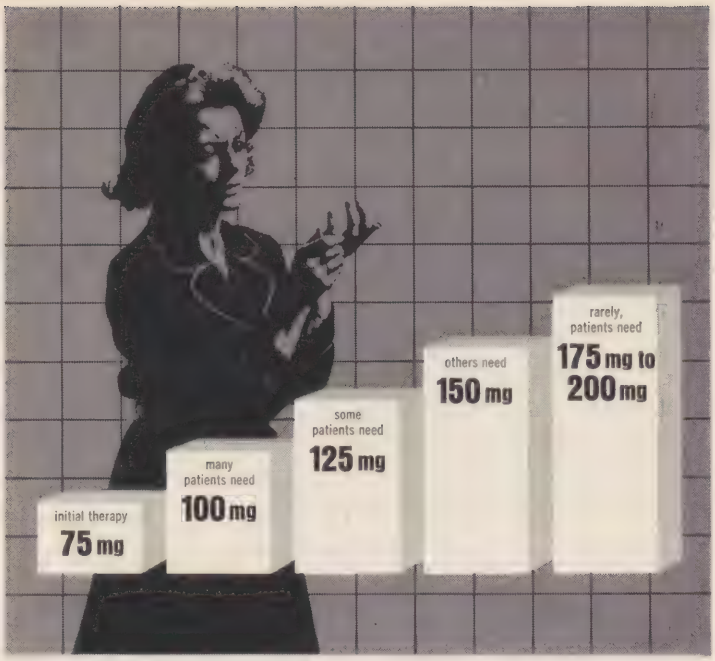
CONTRAINDICATED:

- in aspirin-sensitive asthmatics
- during pregnancy or lactation
- in children
- INDOCIN may mask the signs and symptoms of peptic ulcer and may cause ulceration or irritation of the G.I. tract. Therefore, do not give in active peptic ulcer, gastritis, regional enteritis, ulcerative colitis, and use with caution if there is a history of these disorders.

For additional prescribing information, please see following page.

In selected cases
of rheumatoid arthritis
with acute symptoms

Response to INDOCIN® (Indomethacin | MSD) is often improved by stepping up dosage daily until a satisfactory result is obtained



IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under Indications. The drug should not be prescribed for children because safe conditions for use have not been established.

Indications: For the symptomatic treatment of rheumatoid arthritis, rheumatoid (ankylosing) spondylitis, degenerative joint disease (osteoarthritis) of the hip, and gout.

Contraindications: INDOCIN may mask the signs and symptoms of peptic ulcer and may itself cause peptic ulceration or irritation of the G.I. tract. For these reasons it should not be given to patients with active peptic ulcer, gastritis, regional enteritis, or ulcerative colitis (use with caution if there is history of these disorders); aspirin-sensitive asthmatics. Safe use during pregnancy or during lactation has not been established. Should not be prescribed for children because safe conditions for use have not been established. In a few cases of severe juvenile rheumatoid arthritis receiving INDOCIN along with other drugs, severe reactions, including fatalities, have been reported.

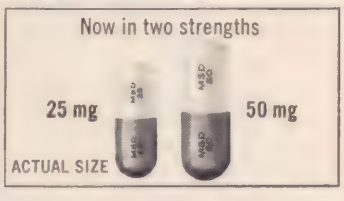
Warnings: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles or machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism since it may aggravate these conditions.

Precautions: Use cautiously in patients with a history of peptic ulcer, gastritis, regional ileitis, or ulcerative colitis because of its potential for causing G.I. bleeding. May cause single or multiple ulceration of the esophagus, stomach, duodenum, or small intestine, and, in a few instances, severe bleeding and perforation with a few fatalities have been reported. May potentiate the ulcerogenic effect of steroids, salicylates, or phenylbutazone. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; the drug should be discontinued if G.I. bleeding occurs. As a result of obvious or occult G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. In common with other drugs that have anti-inflammatory, analgesic, and antipyretic properties, indomethacin may mask the signs and symptoms of infection; avoid undue delay in initiating appropriate treatment of the infection; use cautiously in patients with existing, but controlled, infections. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity.

Adverse Reactions: Starting therapy with low doses, with gradual increases when necessary, will minimize adverse reactions. *Central Nervous System:* Most commonly, headache (usually more severe in morning), dizziness, and lightheadedness; infrequently observed reactions include mental confusion, drowsiness, convulsions, coma, depression, and other psychic disturbances, such as depersonalization; CNS effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. *Gastrointestinal:* Most commonly, nausea, anorexia, vomiting, epigastric distress, abdominal pain, and diarrhea; others that may develop are ulceration, single or multiple, of esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage with a few fatalities having been reported; G.I. bleeding without obvious ulcer formation, increased abdominal pain in patients with preexisting ulcerative colitis; less commonly, stomatitis; gastritis; bleeding from the sigmoid colon, occult in type or from a diverticulum, and perforation of preexisting sigmoid lesions (diverticulum, carcinoma); G.I. reactions not known definitely to be attributable to indomethacin include development of ulcerative colitis and of regional ileitis. *Hepatic:* Rarely, jaundice and hepatitis. *Cardiovascular-Renal:* Infrequently, edema, elevation of blood pressure, and hematuria. *Dermatologic-Hypersensitivity:* Infrequently, pruritus, urticaria, angioneurotic edema, angiitis, skin rashes, loss of hair, and acute respiratory distress including sudden dyspnea and asthma. *Hematologic:* Infrequently, leukopenia, purpura, and thrombocytopenia; rarely, agranulocytosis and bone marrow depression have been reported, but a definite relationship to the drug has not been established; since some patients may manifest anemia secondary to obvious or occult G.I. bleeding, periodic hemoglobin determinations are recommended. *Eye-Ear:* Infrequently, tinnitus, blurred vision, hearing disturbance, and orbital and periorbital pain. *Miscellaneous:* Rarely, vaginal bleeding, hyperglycemia, and glycosuria.

Supplied: Capsules containing 25 mg indomethacin each, in bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in bottles of 100.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.



MSD **MERCK SHARP & DOHME** Division of Merck & Co. Inc. West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

Patient comfort is your concern.

Patient comfort in chronic constipation is enhanced by restoration of normal pattern of evacuation.

- ☐ Gentle neuroperistaltic stimulation is mediated through the Auerbach's plexus in the colon
- ☐ Aids in rehabilitation of the constipated patient by facilitating regular elimination
- ☐ No laxative tolerance or rebound constipation reported in clinical experience
- ☐ Even many previously intractable cases have been successfully treated with SENOKOT preparations
- ☐ Virtually free of side effects at proper, individualized dosage levels
- ☐ Dosage may be gradually reduced and eventually discontinued in many cases, upon restoration of normal pattern of elimination

Dosage: (preferably at bedtime)—*Adults:* 2 tablets (max. 4 tablets b.i.d.). *Children:* (over 60 lb.) 1 tablet (max. 2 tablets b.i.d.). **Supplied:** Bottles of 50 and 100 tablets.



Purdue Frederick

The Purdue Frederick Company, Yonkers, New York 10701

Senokot Tablets

(standardized senna concentrate)

© COPYRIGHT 1969, THE PURDUE FREDERICK COMPANY 36869

That became the topic of a get-together this spring which featured public school specialists in family life education as guest speakers.

The Monroe County Society has screened the film twice to include clergymen new to the community.

The AMA has a new film out now to aid county societies in drawing attention to the need for physicians and clergymen to work together to serve the "whole" person and the "whole" family. Called "A Storm, A Strife," the film dramatizes a family's problems with children, health and marriage.

THE IMPORTANCE of religion and faith to the well-being of the individual is noted by the AMA in official releases such as one which states "Faith, too, is a physician.

"Often, in dark moments," it continues, "faith becomes as powerful as the most potent vaccines, as impressive as the instruments of modern medicine, in restoring the blessings of health."

More light on the important issues discussed between doctors and clergy is shed by Doctor Davenport of Jackson. There is the issue of the inviolability of information given both men by the "patient," and the difficulty of sharing such knowledge so that both physician and minister may better help the individual, he observes.

"Sometimes the minister knows the patient's problems and emotions better than the doctor, also," continues Doctor Davenport. "Organic and functional illness can be caused by the stresses and strains of life and people with religious convictions which motivate their lives are often better prepared to meet these stresses and strains. People who haven't those religious convictions leave the doctor with no one to refer them to for moral strength. I think a doctor should be able to guide a patient who is dying to someone to help him spiritually."

"And," adds Doctor Chapin of Tuscola County, "If we utilize our meetings properly I think they will help us doctors have a better relationship with local ministers so that we will feel we can call on them at a time when we need them, that they will understand our viewpoints and vice versa."

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

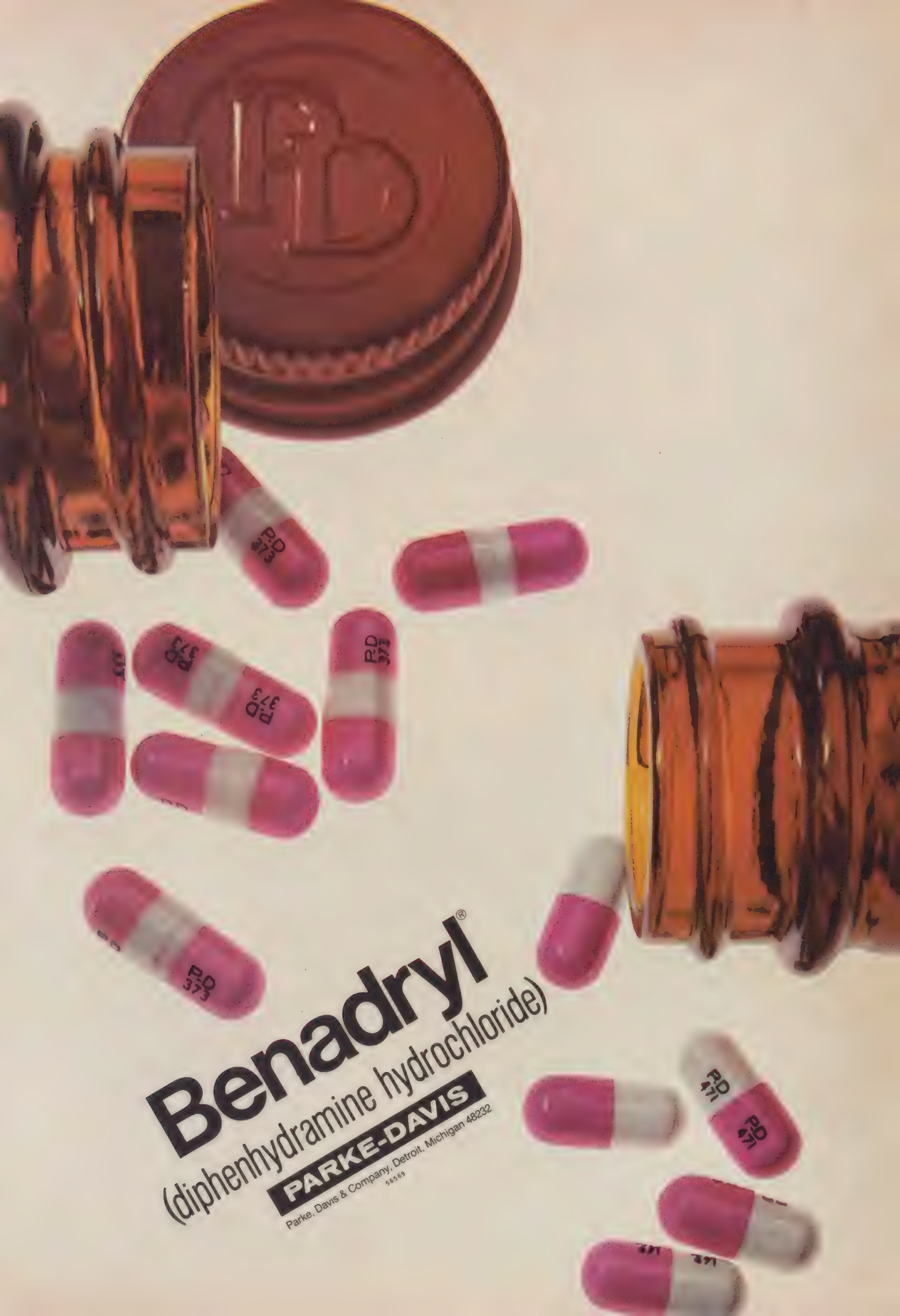
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

DETROIT OFFICE: G. A. Triplett, R. K. Wind and J. K. Galloway, Representatives
27200 Lahser Road, Southfield 48075 Telephone: (Area Code 313) ELgin 3-4348 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative
422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477


Benadryl®
(diphenhydramine hydrochloride)
PARKE-DAVIS
Parke, Davis & Company, Detroit, Michigan 48232
56569

The trouble with women...



frequently
is men

FLAGYL®
brand of metronidazole

Cures Trichomonal Infection in Both

Although *Trichomonas vaginalis* infection occurs in only 5 to 10 per cent* of men, careful diagnosis will demonstrate the condition in about half of all husbands of infected women. Nine investigators* reported an average incidence of 50.8 per cent in exposed consorts.

Many clinicians have achieved a high degree of success in treating trichomonal vaginitis only after they have recognized the importance of sexual partners in perpetuating the infection. Crowley* has asserted, "it was not until we acted on this key premise that we were able to obtain positive and lasting results in our management of recurrent vaginal trichomoniasis."

Simple ten-day oral treatment with Flagyl virtually assures elimination of established trichomonal infection in men. In twenty-two of twenty-seven studies* data on the results of treating male patients revealed that all men treated with Flagyl were cured.

Indications: Flagyl is indicated in the treatment of trichomoniasis in both men and women.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: *In women:* one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

*Complete list of references on request.

SEARLE

Research in the Service of Medicine



...now fast relief of hay fever symptoms with

NTZ®

Nasal Spray

When pollens fly, just one or two squirts of NTz in each nostril, followed in a few minutes by a second spraying, shrink swollen nasal passages almost on contact. And breathing comfort follows. The antihistamine component of NTz helps combat the allergic reaction and lessen rhinorrhea, sneezing and itching; its antiseptic wetting agent promotes rapid spread of components.

NTz Nasal Spray affords the well-known benefits of Neo-Synephrine® in a carefully balanced formula which includes:



Neo-Synephrine® (brand of phenylephrine) HCl 0.5% (adult strength), decongestant

Thenfadil® (brand of thenyldiamine) HCl, 0.1% antihistamine

Zephiran® (brand of benzalkonium as chloride, refined) Cl, 1:5000, antiseptic wetting agent

Treatments with NTz should be repeated every three or four hours as needed. NTz is for temporary relief of nasal symptoms and overdosage should be avoided. Available in squeeze bottles of 20 ml. and 1 oz. bottles with dropper.

Winthrop Laboratories, New York, N.Y. 10016 (12


In dermatologic disorders...

the advantages of ALLERSONE OINTMENT in dermatologic disorders

antiinflammatory
▪
antipruritic
▪
antiallergic
▪
anesthetic

IN THE MANAGEMENT of common dermatologic disorders, ALLERSONE provides more than symptomatic relief for your frustrated patient. Because ALLERSONE combines the antiinflammatory, antiallergic and antipruritic action of hydrocortisone with the anesthetic effect of diperodon HCl, it can make a worthwhile contribution to your therapeutic regimen.

ALLERSONE has long provided safe, effective and economical therapy for the anxious patient plagued by dermatologic problems. In addition, it is greaseless, odorless, colorless, as well as washable; thereby assuring a high degree of cosmetic acceptance.

ALLERSONE
OINTMENT

for effective topical management

COMPOSITION: Representing: Hydrocortisone 0.5%; Diperodon Hydrochloride 0.5%; Calamine 2.5%; Zinc Oxide 2.5% in a water-washable base containing sodium lauryl sulfate, propylene glycol, cetyl alcohol, white petrolatum, methylparaben and propylparaben as preservatives and water.

INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertrigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

ACTION: Hydrocortisone exhibits marked antiinflammatory activity when applied topically to the skin. It is ameliorative in pruritic, allergic and atopic skin lesions. Diperodon hydrochloride is a surface anesthetic, while the calamine and zinc oxide powders are well-known for their mild astringent and protective actions. The remaining ingredients comprise the water-washable base.

DOSAGE AND ADMINISTRATION: Distribute a small amount by gentle application over affected area, two or three times a day; frequency of application to be reduced with improvement.

CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain —while hydrocortisone reduces inflammation—in a water-washable vehicle —no desquamation from fats.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: 0.90 Allersone, pink ointment, available in 15 Gm. tubes and in pound jars.

MALLARD, INC.
PHARMACEUTICAL MANUFACTURERS
DETROIT, MICHIGAN 48216

Thirteen Award Winners Named At Michigan Health Planning Conference

MSMS Council Chairman Ross V. Taylor, M.D., Jackson, presented framed certificates to five honored recipients of MSMS Outstanding Health Service Awards April 16 at the Second Annual Conference for Michigan Health Planning and Related Subjects in Kalamazoo sponsored by MSMS. The awards went to:



Melvin D. Barger,
Jackson industrialist



The Jackson Citizen Patriot
Represented by Hillis Johnson



State Sen. N. Lorraine Beebe,
Republican, Dearborn



George C. Thosteson, M.D., Detroit
International health columnist



Lawrence H. Bush, Science Writer
The Ann Arbor News



State Rep. Lucille H. McCollough
Democrat, Dearborn,
who received her award from
Kenneth H. Johnson, M.D., Lansing
MSMS Secretary

On April 17, the second day of the Kalamazoo Conference for Michigan Health Planning and Related Subjects, seven Michigan physicians were honored with the presentation of MSMS Flag Awards for serving as presidents of statewide groups in the areas of science, youth, education and health. MSMS President James J. Lightbody, M.D., Detroit, gave framed certificates to:



Winthrop N. Davey, M.D.
Ann Arbor
Michigan Tuberculosis and Respiratory Disease Association



Michael C. Kozonis, M.D.
Pontiac
Michigan Heart Association



Fred Whitehouse, M.D.
Detroit
Michigan Diabetes Association



Emanuel Tanay, M.D.
Detroit
Michigan Association For Law and Psychiatry



Don Marshall, M.D., Kalamazoo
Michigan Association For Regional Medical Programs



Alfred H. Whittaker, M.D., Detroit
Michigan Chapter, American Medical Writers



E. Gifford Upjohn, M.D., Kalamazoo
Michigan Health Council

The Camera Records Heart Association's Scientific Sessions

DURING A BREAK between meetings at the Michigan Heart Association's 20th Annual Scientific Sessions staged recently in Detroit, this group paused to discuss the two-day proceedings. From left they are Michael G. Kozonis, M.D., Pontiac cardiologist and president of the MHA; James K. Alexander, M.D., director of cardiovascular research, Baylor University, keynote speaker; Park W. Willis, II, M.D., professor at the U-M Medical Center Heart Station, and Donald C. Overy, M.D., Pontiac cardiologist and chairman of the Scientific Sessions program committee.



ABSORBED IN CONVERSATION at the April 11-12 meeting are Abraham Brickner, left, executive director of MHA, and Ernest W. Reynolds, M.D., electrocardiologist at the U-M Medical Center Heart Station.



PAST, PRESENT AND future MHA administrations are represented by, from left, Muir Clapper, M.D., WSU professor, former MHA president; Edward W. Green, M.D., Detroit, chief, pediatric cardiology, Children's Hospital of Michigan, MHA president-elect, and Doctor Kozonis, current MHA president.



New Construction At Michigan's Medical Schools



MICHIGAN'S FIRST SCANNING electron microscope for biomedical research was installed last winter at the WSU Medical Research Building, first new structure to go up in the Detroit Medical Center.



A FUTURE LECTURE hall takes shape in the new WSU Basic Science Instruction Facility.

DETROIT MEDICAL CENTER view shows (from left) the parking structure and the new 320-bed building for Children's Hospital of Michigan, with the WSU Basic Science Instruction Facility construction in the background.





A PHOTO OF the University of Michigan campus pinpoints locations of recent construction. At A, is the new Towsley Center for Continuing Medical Education; B, the new C.S. Mott Children's Hospital; C, the site of the Upjohn Clinical Pharmacological Research Building now under construction and D, the Medical Science Building II, recently completed.



AN ARCHITECT'S MODEL of the proposed Life Sciences Building at Michigan State University shows Unit I, at left and lower center, already completed; and Unit II, right and top center, which will contain a teaching hospital and outpatient center needed to expand the School of Human Medicine's program to four years.

A $2 MILLION, three-story, 154-bed extended care facility, "Georgian Northwest," is being constructed on Hubbell Avenue near Puritan in northwest Detroit, near Mt. Carmel and Sinai hospitals. Georgian Court of America, a wholly-owned subsidiary of Walter Kidde & Company, is the operating company. The building and equipment conform to all the federal standards of Medicare, the State Health Department and the Federal Housing Authority, which insured a $1,519,700 mortgage loan. Mrs. Marjorie E. Dolezel, R.N., is administrator.





MICHIGAN HEALTH COUNCIL'S Health Careersmobile was host to scores of youngsters at an early spring visit to one of the inner-city Detroit schools. J. A. Doherty, executive director of the MHC, stands at right near end of crowd.

MSU Scientists Discover Leaf Peroxisomes





MICHIGAN STATE UNIVERSITY scientists have opened the possibility of an entirely new method of energy and growth control for plants and animals, including man, through their discovery of peroxisomes — "enzyme packages" — in leaves of plants. N. Edward Tolbert, Ph.D., professor of biochemistry and head of the MSU group which made the discovery, reports that the relative simplicity and apparently nonessential role of peroxisomes in some systems suggests they might be easily manipulated to accelerate growth. At left above, MSU biochemist Angelika Oeser prepares peroxisome fractions for study of the enzymes of the peroxisomes, while Doctor Tolbert, center in right photo above, discusses the peroxisomes with Miss Oeser and biochemist Russell Yamazaki.



MORE THAN 1,000 severely retarded children are enrolled in 56 community-based Day Training Centers like Muskegon's, operated by local agencies with funds provided by the state. These are contractual services under the auspices of the Michigan Department of Mental Health. Most of the children are on waiting lists for state institutions, but after receiving basic training at the centers some children are able to transfer to public school special education programs.



AMONG THE MICHIGAN Department of Mental Health's newest facilities is the Muskegon Regional Mental Retardation Center (artist's model at left). This 254-bed facility provides residential, day training and outpatient services to residents in a six-county district. First admissions were in January.



MEMBERS OF THE MSMS Committee on Nursing and representatives from the Michigan Nursing Association who met recently to re-emphasize the importance of MSMS-MNA cooperation were, from left, Gwendoline MacDonald, R.N., Ed.D., MSU School of Nursing, committee co-chairman; Lucy Brand, R.N., St. Clair Shores; Shirley Austin, M.D., Belleville; Robert L. Tupper, M.D., committee chairman; Joan Guy, R.N., MNA executive director, and Lillian Ostrand, R.N., Ann Arbor.



HOLLAND'S CIVIC CENTER was the setting recently for the second annual "Career Worlds" show for Holland high school students. In center back, the Michigan Health Council's Health Careersmobile holds a prominent position, while inside, the "Medical World" section proved to be the most well-planned and executed.



TYPICAL OF THRONGS which crowded the Ottawa County Medical Society's popular exhibit, these youngsters watch demonstrations of surgery and anesthesia by Joyce Alderink, R.N., Jerome Wassink, M.D., and William Winter, M.D.

CAREER WORLDS SPOTLIGHTS MEDICINE

See related story, Page 625.



CAREER WORLDS LEADERS taking notes are, from left, general chairman, Vern Schipper of the Holland Chamber of Commerce; Roscoe Giles, C. of C. executive vice president, and Donald DeWitt, M.D., originator of the first career day, in 1968, and co-chairman of this year's program.



QUARTET OF INTERESTED tenth grade boys hears anesthesia explanation from Dr. Winter. The Career Day originated in 1968 as a "Medical Worlds" exhibit.

Holland Career Worlds Exhibition Excellent Vehicle for County Society

BY JUDITH MARR
MANAGING EDITOR

"Is the surgery room a pretty gory sight?"

"How many years of college does it take to be able to do surgery?"

The questions were typical of those asked by the Holland high school students.

And to the first William Winter, M.D., answered "Not at all, though it does take a while to get used to it." To the second his reply was, "About 12 years and it's not hard at all. All you have to do is decide to work at it."

Doctor Winter was manning the Ottawa County Medical Society's booth in the World of Medicine section of the second annual Career Worlds exhibition in the West Michigan city.

He and several other Holland-area doctors took part in the effort that is an excellent example of a county society project to inform the public about the world of medicine and at the same time attract prospective doctors.

The two-day Career Worlds exhibition, staged at the Holland Civic Center, attracted a total of 1,750 youngsters, most of them in the Holland schools' tenth grades, to view aspects of careers they might choose in the Worlds of Medicine, Education and Business.

It grew out of a World of Medicine exhibition staged in 1968 by the Ottawa County physicians. This year the section on medicine was the most complete of all three divisions.

OTTAWA EXHIBIT MOST POPULAR

The Ottawa Society's display of surgery and anesthesia, complete with instruments, a mannequin draped for an appendectomy and an anesthetizing machine, was one of the most popular of all the exhibits, steadily attracting throngs of youths who surrounded the doctors and nurses in charge.

The originator of the career day exhibition, according to this year's general chairman, Vern Schipper of the Holland Chamber of Commerce, has been Donald DeWitt, M.D., of the Ottawa Society. Doctor DeWitt was chairman of this year's World of Medicine.

Doctor DeWitt approached the Chamber of Commerce in 1968 with an idea to expand the careers program the C. of C. already presented to the local high school students. It consisted in a series of several conferences held one night at each school. The students would pick two they thought most interesting and listen to lectures on the occupations.

Doctor DeWitt told the C. of C. he thought the students ought to be able to learn of more than two types of careers and informed the organization that the medical society wanted to expose the youngsters to medical and paramedical fields.

"It was largely through his pushing that we came up with this idea," says Mr. Schipper.

Thus the World of Medicine show was staged in 1968. And this year it became the expanded Career Worlds exhibition.

"The students this way have a better idea of careers to choose from," says Doctor DeWitt. "Maybe they've never heard of medical records before. Or maybe some kid likes what he sees with the telephone company and wants to hear more about that."

That is precisely what has happened to several young Holland citizens, according to a pleased Tom Carey, director of counseling in the Holland Public Schools.

MEDICINE HAS CENTRAL SECTION

In this year's exhibition, which divided the large floor of Holland Civic Center into three main sections and also utilized outside corridors, the World of Medicine occupied the center section. Tenth graders disembarking from school buses at the front door were able to visit exhibits of veterinary medicine, X-ray technology, medicine, medical records librarians, medical technology, dentistry, pharmacology, medical office assistants, nursing and physical therapy.

The students were allowed 20 minutes in each "World," then given free time at the end of their visit to return to any exhibits which particularly interested them. Evenings hours were provided for youths from 11th and 12th grades and their parents, as well as interested tenth graders who wished to explore a career interest even further.

The purpose of the entire effort, explains Mr. Schipper, is to acquaint the youngsters with a broad base of opportunities in a variety of fields as they plan for their high school careers.

The long years of schooling required to become a surgeon were clearly on the minds of a majority of the youth who visited the Ottawa County Medical Society's booth. And the doctors who manned it, like Doctor Winter, were careful to instruct the youth that a surgeon was only one part of the health team.

Other Ottawa Society members who participated included Jerome H. Wassink, M.D., chairman of the exhibit; Bernard Meeuwsen, M.D., chairman of the public relations commitee which organized the society's display; Owen J. Gesink, M.D.; Robert Albers, M.D., and Paul Dykema, M.D.

A high index of suspicion... E. coli

How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

Consider wide-spectrum Gantanol® (sulfamethoxazole) for its high "index of confidence"—its proven effectiveness against *E. coli* and other sensitive gram-negative and gram-positive organisms. Therapeutic levels of Gantanol in blood and urine are achieved within 2 hours after a 2-Gm starting dose, with ready diffusion into interstitial fluids. Responsive infections generally clear within 5 to 7 days, with relief of symptoms usually seen within 24-48 hours.

Gantanol also earns its high "index of confidence" because Gantanol therapy is relatively free from complications, including the problem of bacterial resistance or superinfection.

Convenient, economical dosage schedule: *b.i.d.*

References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days*. Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

For a high index of confidence... Gantanol® (sulfamethoxazole) in antibacterial therapy

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Editorial Note: Michigan Blue Shield believes that it needs a majority of the practicing physicians in Michigan to be formally participating to make its new Variable Fee Program effective. So far the percentage of participation has been disappointingly low. To "perk up" the participation percentage the Blue Shield Board of Directors was advised to discontinue the per-case participation agreement which was announced at the beginning of MVF, but disapproval from The Council, county societies and individual physicians around the state has caused them to drop the subject until December.

In an attempt to spotlight the many ramifications and philosophies of this problem, MICHIGAN MEDICINE presents the following Viewpoints. Doctor Masters' lead-off opinion was submitted to doctors around the state for comment. It must be emphasized that these are the opinions of the writers only, and they are presented with the desire to make all members of the Michigan State Medical Society examine their own approach to Michigan Blue Shield in this year 1969.

Doctors Discuss Blue Shield Proposal To Drop Per-Case Participation

Urges End To Complaining

BY BROOKER L. MASTERS, M.D.
FREMONT

Blue Shield reports 80% of its regular business now has its Variable Fee program; 3.5 million of a total 4.4 million members. By the end of 1969, 95% of all business will be under MVF.

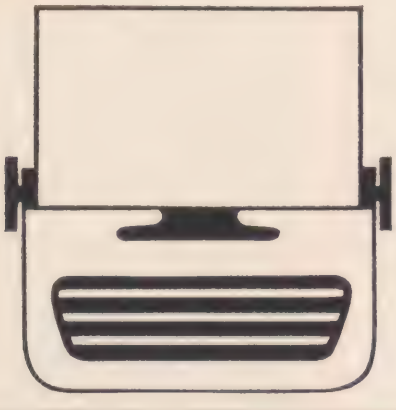
An in-depth study shows that in over 99% of claims submitted the charges made by Michigan doctors were within the Blue Shield prevailing "screen" or the reasonable charge determination by Blue Shield. Including non-participating doctors, 93% of the claims submitted are on a pay-doctor form.

In view of these statistics, perhaps Blue Shield is on solid ground in being perplexed when it considers that formal participation by Michigan doctors is a disappointing 68.3%. Among the Blue Shield plans servicing the Auto accounts, participation ranges from 75% in California and New York City to 99% in Massachusetts. Of the 12 plans, 10 have participation levels over 85%; 8 are over 90%. Obviously Michigan doctors consider the Blue prepayment mechanism from a much different light.

In an effort to beef up the participation percentage to a more meaningful level Blue Shield proposes to eliminate the per-case participation agreement. Thus participation would revert to the former style; either one participates or he does not; formally; yes or no. If I am any judge of the Michigan medical politic, this will cause another crisis in Blue Shield's relationship with its founding medical society.

At the risk of stating the obvious or being asked to retire to my comfortable home in Fremont, I might ask: "Why"? Since 1948 I have constantly heard the complaint that Blue Shield did not represent the doctors, that it was not "our" plan, and that it should be dropped. These charges just are not true.

Sixty percent of the Blue Shield Board of Directors are physicians, elected by our House of Delegates. These are honorable, dedicated men who *do* represent us. Blue Shield monthly reports to the Council on all its activities. It constantly seek M.D. guidance through advisory panels and state-wide professional liaison men. It reports reg-



EDITORIAL VIEWS

ularly in *Michigan Medicine*. Its vice president for Medical Affairs, Louis Hayes, M.D. is one of us. 95% of all its income is returned to the physicians in Michigan as payment for services: $1,000,000 per day. Is there any commercial program that can match this?

The MVF program was designed to pay our usual or customary fees. It is doing so in 99% of the cases. It can be adjusted upward, and has been 5 times since its inception.

As physicians we may wish the third party payment mechanism would dry up and blow away. We know it never will. The consuming public, our patients, want prepaid medical insurance, and more of it. This is the fact of today, and it is only becoming a stronger feature each year.

I think it is high time we members of the Michigan State Medical Society quit our carping at the minor deficiencies of the Blue Shield program, and honestly consider its enormous positive advantages to us. It seems to me we owe it to our patients, to ourselves, and to Blue Shield to immediately increase this participation percentage to a healthy 80-85%! Or do you really want the government to set our fees?

Has Rebuttal To Doctor Masters

BY RALPH F. ASKAM, M.D.
MUSKEGON

As I understand it, the Enabling Act, giving birth to Blue Shield, took from the best of two worlds. Blue Shield made it possible for patients to preserve their dignity by providing recompense for the many doctors who were providing their treatment for free, and it gave *some payment* to doctors who would ordinarily not receive any. A noble and worthwhile enterprise that long ago ceased to exist! As we all know, the majority of these patients have been obliterated and absorbed by many political and economic changes. Why now, then, Blue Shield?

We have been told for years, that the "Blues" were our only defense against Government medicine. Since this propaganda has become past history, the tune is now that Blue Shield is our only defense against fixed fees. We are told repeatedly that the patient knows what kind of patient care he wants, and that Blue Shield not only can supply this want better than any other agent, but also knows best what the patient needs. I have been repeatedly told by Blue Shield professional representatives that Blue Shield feels responsible not only for the economics of its members, but also for the adequacy of its medical care. Should this be the function of any "insurance company"?

My plea is that the doctors of Michigan divorce themselves from negotiations with any third party, not just with Blue Shield, but with any insuring group, union, or whoever.

I think that doctors of medicine should be at the forefront encouraging and leading their constituents back to some degree of responsibility. I say that our contract is with the patient; it is his responsibility to fulfill this contract. Our only economic duty should be to make a just and reasonable appraisal of our services for this contract. Disputes in this direction can and have been handled by local county medical societies for many years.

The critique of the above is that the patient will turn to our favorite uncle for advice. I find it hard to believe that an unfettered free enterprise system can't solve this. I think we can logically assume that there is a market for this consumer. Why else does Blue Shield so desperately need our signed participation to sell these programs. I firmly believe that if the doctors removed their endorsement from Blue Shield and that if the legislature removed the Enabling Act's advantages, and let Blue Shield function as any private insurer, that the patient might well end up with a more favorable product.

In this age of the computer is it not believable that insurance companies can estimate what their medical care dollar will buy in any given area?

Perhaps the foregoing is a gamble. But I have trouble distinguishing the difference between the Federal Government telling me how to practice and Blue Shield telling me how to practice.

I realize there is an obvious answer to this. As Doctor Masters points out, 60% of the Blue Shield Board are Doctors of Medicine. And Doctor Hayes reports to the council. As Doctor Masters also says, since 1948 he has been hearing how unresponsive this board has been to the doctors' complaints. It has been my observation that as soon as a doctor is elected to the Blue Shield board he becomes a Blue Shield enthusiast. Such is perhaps the value of the "professional liaison" men that Doctor Masters mentions. Or perhaps the doctor who accepts this nomination is already sympathetic, or perhaps politics comes up with a desirable candidate. Could this happen in our House of Delegates?

I wonder if all the readers are aware that Blue Shield does not have to answer to the House of Delegates for any of its actions? The Council does get a briefing from Blue Shield. I have read a fair number of these. The Council in January advised Blue Shield that its current letters to patients implied an unreasonable charge and that this undermined a good doctor-patient relationship. The Council's recommendations had little effect, as our patients were still receiving these letters in March.

I never was much at figures, but I can't find any of the people that participate any place close to the 90% or for that matter who always get paid the same fee for the same procedure and same charge. I know the people we deal with do not get paid 90% of their bill 90% of the time. Perhaps this is because I don't participate. Now there really couldn't be any discrimination between one or the other kind of doctor, could there be? And of course we wouldn't even dare think of harassment, would we? Not from our own doctors' program — preposterous!

Doctors of Michigan, I say to you that it's time we placed our "foundling child" up for adoption and got back to the much more earnest business of practicing medicine. I dare say that the retrieval of medical man-hours alone would go a long way to equalizing the output of doctors from one medical school per year. We are doctors, not insurance agents, not economists, but responsible citizens who still have the power, and should have the courage, to convince the patient that ultimately his best medical care can only result from not diluting or abrogating the doctor-patient relationship.

A Re-evaluation And a Time for Change

BY JOHN R. YLVISAKER, M.D.
MSMS TREASURER

In 1939, Michigan Medical Service was founded by altruistic Michigan physicians seeking an effective solution to the problem of the economic devastation caused by catastrophic illness. A close-working relationship and interdependence evolved between Blue Shield and the Michigan medical profession which has continued relatively unchanged to the present. The circumstances which produced this relationship were unique.

At its inception, Blue Shield represented a pioneer effort to provide health care to the consumer of limited means on a prepaid basis at a fixed cost. The concept was revolutionary. No actuarial data existed. The plan couldn't be marketed without the consent of the great majority of physicians to accept the third party payments of Blue Shield as full satisfaction for services rendered.

THE GOAL was humanitarian and the principle was entirely consistent with the Hippocratic morality of medicine. The mechanics of prepayment were acceptable to most practicing physicians and thus the "participating physician" was born.

In 1969, a completely different set of circumstances prevails. Blue Shield is now a mature insurance carrier with a sound actuarial experience in the field of prepaid medical care. It is, or should be, consumer-oriented and carries as its sole and primary responsibility its contractual relationship with the subscriber. The subscriber, however, is no longer limited to income levels. He operates from a wide diversity of economic security. He is most commonly represented at the bargaining table by sophisticated professionals who negotiate the commodity of medical services not with the supplier of the service but with Blue Shield.

Paradoxically, and somewhat incongruously, Blue Shield not only represents the subscriber but also represents the participating physician, upholding fee programs or schedules separately developed by consent of coercion with organized medicine. The policies of Blue Shield are estimated through its board of directors, 60 percent of whom are physicians. The dollar-amount of subscriber premiums is inevitably a consequence of the costs imposed largely by pre-determined fee programs.

In the economy at large, such a process is labelled "price-fixing." In this instance it is the result of a form of collusion, intentional or unintentional, between the medical profession and Blue Shield. The process is no longer consistent with the ethical standards and stated morality of the medical profession. It is basically unethical and must be recognized as an improper relationship.

THE MEDICAL profession has now reached a point in time when disentanglement from any formal relationship with Blue Shield is essential for each to remain untainted.

Such disengagement need not involve ill will or dissension. It should rather allow for a mutual consultative or advisory relationship. However, the concept and practice of participation should be ended with a return to proper ethical standards, in the basic three-party relationship:

(1) the physician-supplier is responsible to the patient-consumer for medical services required;

(2) the patient-consumer is responsible for payment to the physician-supplier for medical services rendered;

(3) Blue Shield, the insurer, is responsible to its subscribers for contractual benefits as specified, and lastly,

(4) The medical profession remains responsible to itself and society at large for supervising the quality, distribution and costs of medical care for the protection of the consumer.

"Shall I order Maalox?"





"Yes. Patients respond well to it, and seem to take it more faithfully."

Works well · Doesn't constipate · Tastes good · Economical

Supplied: Maalox Suspension (12 fl. oz.). *Also available:* Maalox No. 1 Tablets (0.4 Gm.) : no sugar, low sodium content. Maalox No. 2 Tablets (0.8 Gm.) : double strength for double antacid action.

THE NUMBER ONE ANTACID

Maalox®

MAGNESIUM-ALUMINUM HYDROXIDE

ROHER

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

Doctor Kerlikowske's Retirement Is Michigan's Loss

BY BROOKER L. MASTERS, M.D.
CHAIRMAN
MSMS PUBLICATIONS COMMITTEE

With the retirement on June 30, 1969, of Dr. Albert C. Kerlikowske from the directorship of University Hospital, Michigan medicine loses from this crucial spot the services of one of its staunchest champions of exemplary patient care.

"Kerley," as he is best known by physicians, patients and fellow administrators throughout the state, got into hospital administration in 1929, six years after he graduated from the U-M Medical School. He was chief resident in ophthalmology when he was invited to become assistant director of the hospital. He was appointed director of the institution Sept. 1, 1945.

NOT THE LEAST of the administrative tasks of running a $38-million-per-year teaching hospital is the constant problem of steering an effective course between the needs of patients, researchers, teachers and students.

The issue recurs in a thousand disguises. Among the 875 physicians at the U-M Medical Center are many of the world's prominent researchers and articulate teachers. There are about 2,500 students there who are building the foundation for their careers in the health sciences. Fulfilling their manifold demands and requirements while maintaining a climate of absolute patient consideration would test the wisdom of Solomon.

SOMETIMES THE NEEDS of teaching and research can appear to infringe unfavorably upon the patient's pocketbook, treatment or general well-being. In any such instance, Kerley was certain to enter the lists to champion the needs of the patient. Not a few researchers whose enthusiasm for investigation outweighed their consideration for the person who was ill, have had a command session with Kerley. They have come away from those sessions with a fresh awareness that the scientific aspects of medicine must also rest on, and be tempered by, a basic humanitarianism for the sick individual.

This does not imply that Kerley has been the only person at the U-M keenly concerned with patient welfare. Nor even that he has been more concerned or adroit in these considerations than many of the fine clinicians at the institution.

But the obvious fact remains that for a quarter century he has held the key position at University Hospital — itself considered by many to be the keystone of clinical care in the state. He has used his perspicacity, wit and persuasiveness to make that institution serve the people of Michigan, and serve them well.

Team Effort Needed

BY ARCH N. BOOTH
EXECUTIVE VICE PRESIDENT,
CHAMBER OF COMMERCE
OF THE UNITED STATES

The Nixon Administration makes it very clear that businessmen will be relied upon to produce much of the leadership required for cleaning up the hard-core unemployment, welfare, housing, crime and other related urban problems.

The business community has been waiting 35 years for this kind of an expression of confidence in free enterprise as a force for social, as well as economic, good. The idea that only government cares for people has smeared our image for much too long a time. It has also permitted the people's problems to grow worse.

Now, in order to save the whole man-made community environment from disaster, the businessman must come to the rescue.

The fact that a new, business-like Administration is urging our cooperation makes it easier for us to get involved. As we respond, however, we find ourselves on strange ground. The businessman is exploring new territory in business-government relations. There are no guidelines, and some dubious stockholders are looking on. Such a businessman knows how some astronaut will soon feel in planting man's first footstep on the moon.

Like the astronaut, he must have expert backing. He needs the support of a capable, experienced team, one that can be provided nowhere else quite so well as by his local chamber of commerce or his trade or professional association.

Let's face it, there is really no other effective way for a businessman to work with government on broad welfare problems.

Since so much depends on the business effort, it must be organized so that it can make its best possible contribution. And in any sort of partnership arrangements with government, businessmen will need to follow free enterprise principles.

By working with your chamber or association, you will be on a team that understands the proper ways of developing closer business relations with government.

Doctor, Does Your Wife Belong To The Woman's Auxiliary to MSMS?

BY MRS. EDWARD S. MAXIM
PRESIDENT-ELECT
WOMAN'S AUXILIARY TO MSMS

The prime strength of any organization lies with the individual members. All the truly important work is accomplished at the local level. It is here that the lasting impact is made on the community; here that the Auxiliary performs its distinct service to the Medical profession.

The Auxiliary was formed for these purposes:

1. To assist the American Medical Association in its programs for the advancement of medicine and public health.
2. To coordinate and advise constituent (county) auxiliaries.
3. To cultivate friendly relations and promote mutual understanding among physicians' families.

All organizations go through a certain amount of change and ours is no exception. However, the basic reasons for our organization are still pertinent today.

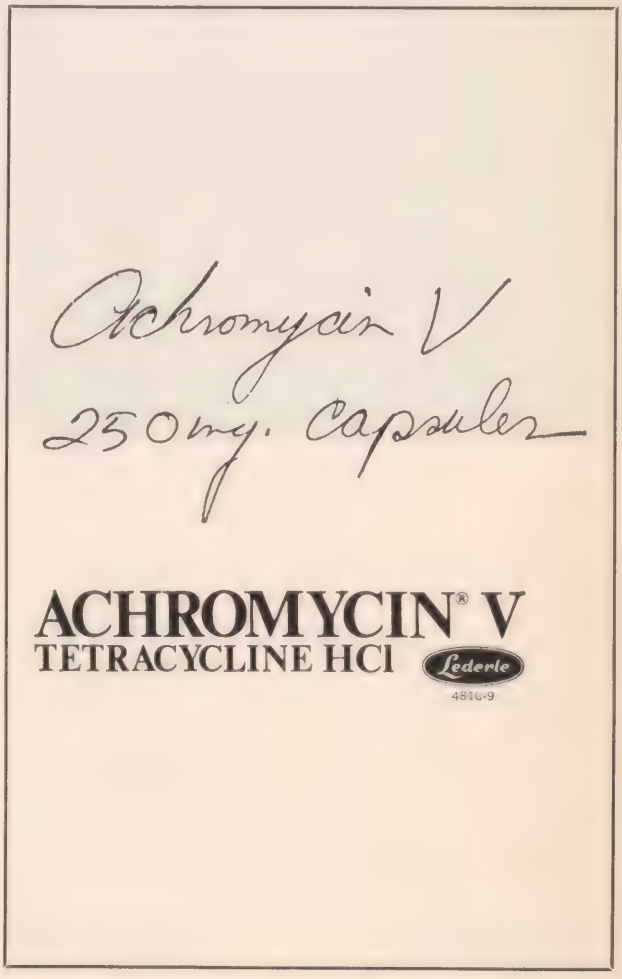
The membership of the State Medical Society has increased by more than 1,000 this year. Unfortunately the Medical Auxiliary has not been able to show this kind of an increase in its membership; as a matter of fact it experienced a slight decrease in membership this year. We now number just under 3,500, while the Medical Society membership is over 8,700.

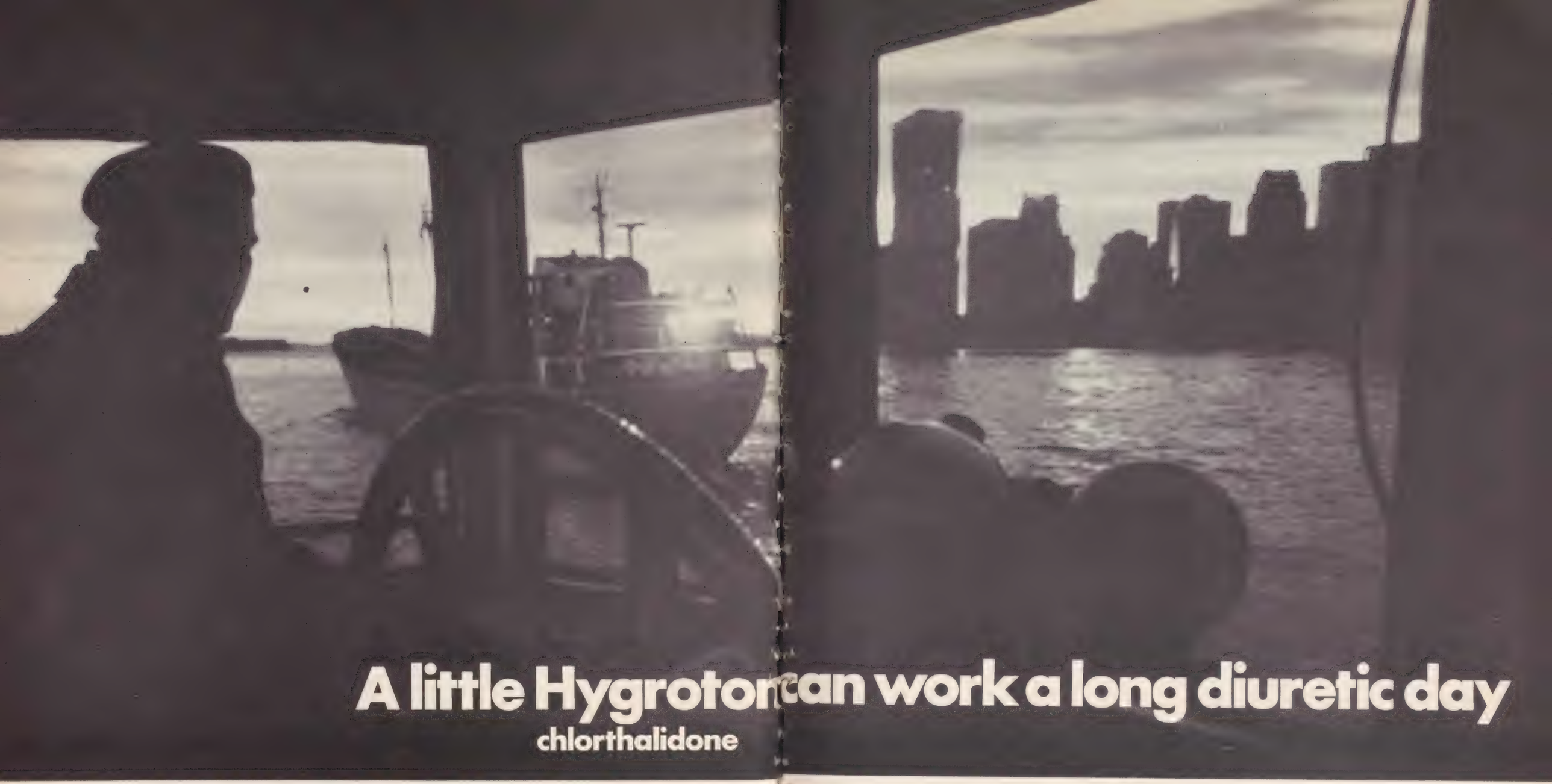
We encourage the wife of each physician to join the auxiliary by (1) having leaders who are enthusiastic and knowledgeable; (2) having good programs that have the three essential ingredients of friendship, fun and facts, and (3) having worthwhile projects.

Yet as important as the above points are, they are not the real key to recruiting and retaining members in the Auxiliary. The most important key is you, Doctor. Your attitude is most important. If you believe in the work of the Auxiliary, if you believe it is important for your wife to be a member and if you are willing to encourage her in this work and let her know that what she is doing is important to your profession you can be the greatest aid to attaining a larger membership.

How familiar are you with the work of the Auxiliary? Are you aware that the Auxiliary members throughout the State of Michigan raised $20,994.82 for the American Medical Association-Education Research Foundation this past year, are working diligently to recruit young people into the many health careers necessary to enhance your work, and try to keep posted on legislation to inform our legislators as to what you feel is in the best health interest of people?

These are but a few of our many activities. We are ready and willing to promote any of your programs or projects. Our main objective is to be of assistance to you. But won't you help us by encouraging your wife to become a member of the Auxiliary? Our being depends on you.





A little Hygroton can work a long diuretic day

chlorthalidone

...ll the way from one daily tablet to the next
...o help control edema and hypertension

...s prolonged action usually provides smooth, sustained diuretic ...ffectiveness; real one-a-day dosage, right from the start; convenience ...nd economy.

...ygroton, chlorthalidone, can cause side effects. And it's contra-...dicated in hypersensitivity to the drug and severe renal and ...epatic diseases.

...heck the prescribing information. It's summarized on the next page.

Geigy

HY-6674



A little Hygroton® can work a long diuretic day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502



Figure A shows a typical focus resulting from the rapid growth of cells after virus infection in the study of viruses and cancer at Ann Arbor.

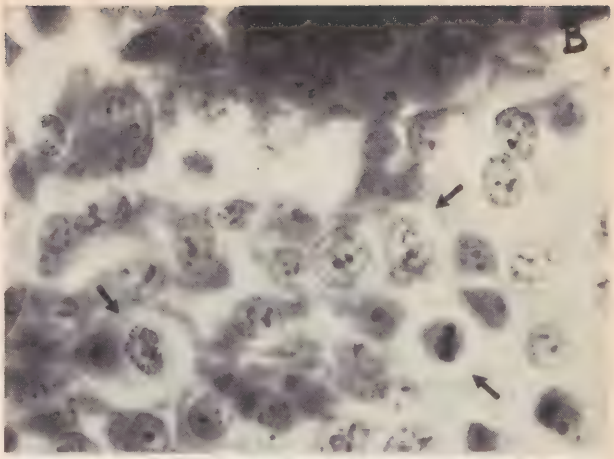


Figure B shows cells at high magnification illustrating mitotic figures characteristic of rapidly dividing cells.

Review of Cancer Research And Patient Care at U-M

BY ELIZABETH GALL
ANN ARBOR MEDICAL WRITER

Who is doing what in cancer research at the University of Michigan?

This is a tough question to answer because so much is going on. To help interested people, the U-M Office of Research Administration has prepared a 42-page, illustrated survey, "Cancer Research and Patient Care," of projects underway at the University.

Under four main headings — The Causes and Biology of Cancer, The Diagnosis of Cancer, The Treatment of Cancer, and The Tumor Registry — are listed the kinds of ongoing projects that cross disciplinary boundaries. Names of U-M cancer researchers are followed by the departments where they are working and descriptions of what they are doing.

"Even the scientists involved can barely maintain a nodding acquaintance with the work of their colleagues in related fields," observes writer Paul Cornelius. Chairman of the Cancer Research Committee, Burton L. Baker, M.D., of the Department of Anatomy, served as consultant for the survey and report. Designer is Cyril Barnes.

Various teaching, research, training, and patient treatment programs are listed and linked to their sources of financial support, much of which is obtained through the U-M Cancer Research Institute.

The following list of investigators and their projects are surveyed in the article comprising the entire January/February issue of the U-M's *Research News*, Volume XIX, numbers 7 and 8:

THE CAUSES AND BIOLOGY OF CANCER

Viruses and Cancer. Payne: studying tumor-producing viruses in animals and human tissue culture; Murphy: leukemia in mice and humans; Zarafonetis and Dabich: fluorescent antibody technique for studying abnormal bone marrow cells of leukemic patients; Nace: possible viral cause of cancer in frogs.

Hormones and Cancer. Midgley and Jaffe: basic biology of reproduction, also aspects of tumor growth and irregular hormone secretion; Kahn and Baker: mammary tumors in mice, oral contraceptives and prolactin.

Immunology and Cancer. Holmgren and Merchant: how different types of cells interact and destroy one another; Whitehouse: why some antibodies do not kill cancer cells, why some protect them.

Studies of Chemical Carcinogens. Dodson and Naylor: asbestos and tumors, and pesticides related to leukemia and tumors.

Cellular Differentiation Studies. Floyd: studying mechanisms controlling differentiation of cellular nuclei in roundworm uteri; Conklin: changes in embryonic enzymes as cells specialize; Burdi: how



The mouse on the right has no tumor. The mouse on the left has a sarcoma SA-1, a tumor used in immunological enhancement studies in the U-M Department of Microbiology.

mice teeth develop differentially, and control mechanisms.

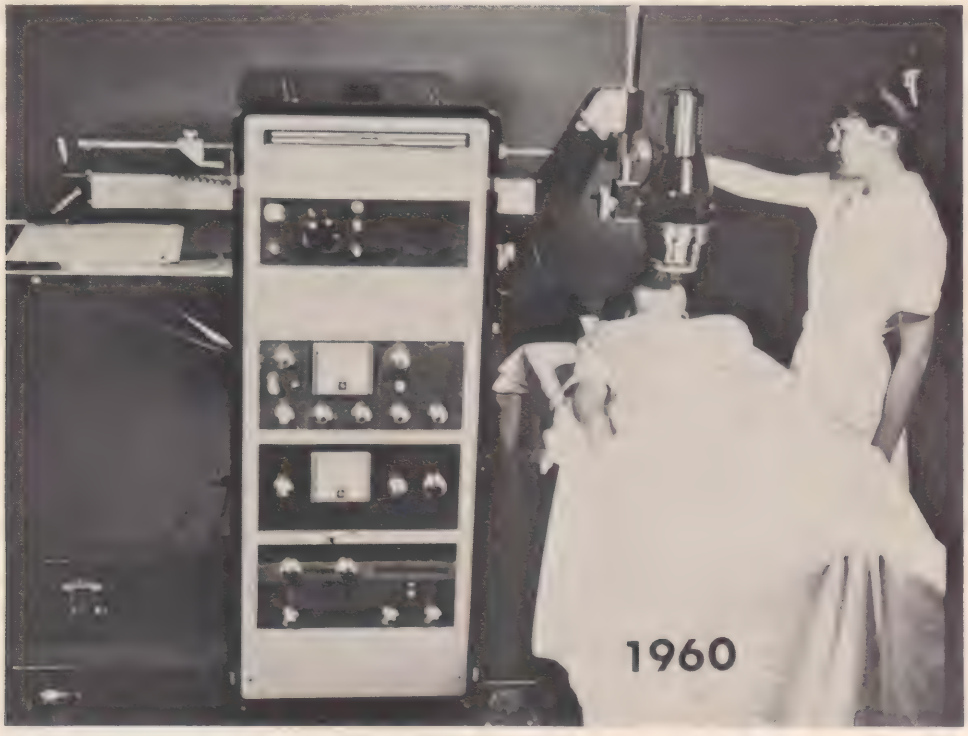
The Metabolism of Tumors and the Host. Bernstein: how ascitic hepatoma in rats changes DNA synthesis in their liver; Bauer: effects of cancer on the metabolism of the host.

THE DIAGNOSIS OF CANCER

General Laboratory Procedures — Cytological Diagnosis. Naylor: studying exfoliated body surface cells suspected of being cancerous, use of them in teaching to prevent diagnostic errors; Wolter:



An investigator is demonstrating the method by which a radioactive compound is added to a hormone in studies of hormones and cancer at the U. of M. The radioactivity-labeled hormone will be used to determine whether patients with placental cancer have been cured.



An eighth-inch (sodium-iodine) crystal scanner being used in diagnostic nuclear medicine studies at the University of Michigan. It scans 10 times faster than the older three-inch scanner.

improved techniques for better diagnosis of eye cancer; Turtelotte: standardized diagnostic test for cancer metastasis to the brain.

Procedures — Histopathological Diagnosis. Abell: differential diagnosis of adenocarcinoma and benign tumors, and lymphomas and lymphoid hamartomas; Wolter: relationships between two or more tumors.

Procedures — Hormone and Enzyme Detection. Midgley and Jaffe: hormone assays for early detection of choriocarcinoma.

Procedures — New Instruments for Diagnosis. Pollard, Bolt, and French: developed several instruments for diagnosis of cancer in stomach and small intestines, developing instrument for colon.

Diagnostic Nuclear Medicine. Beierwaltes, DiGiulio, Lieberman, Gates and Counsell: develop investigative, diagnostic, and treatment procedures using radionuclides and radionuclide-labeled compounds.

Diagnostic Radiology. Kittleson, Whitehouse, Bookstein, and Lalli: testing and developing new detection techniques for breast cancer, kidney tumors, and using vascular methods of cancer diagnosis and treatment in all parts of the body.

THE TREATMENT OF CANCER

Surgery. General Surgery Section: ten-year followup study of patients with total thyroidectomies; also studies after removal of pancreas and breast cancer; experimental intestinal transplants in dogs. Urology Section: cobalt radiation therapy combined with surgery for cancer of prostate. Plastic Surgery Section: study of carcinoma of skin and new operation for cancer of floor of mouth. Thoracic Surgery Section: abdominal operation to detect spread of lung cancer before attempting lung removal. If found, lung not removed. Gastroenterology Section — Internal Medicine: years-long study of metabolic changes in patients after stomach removal, and study of cancer of colon. Morley: present head of Gynecology Cancer Tumor Service; surgery and radiation treatment. Taylor: chemosurgery for skin cancer. Work and Boles: diagnosis and treatment of cancer of ear, nose and throat.

Radiation Therapy. Lampe and Fayos: daily treatment and followup studies of cancer treated with radiotherapy; Alice Crocker Lloyd Radiation Therapy Center — five treatment rooms; Wolter: study of eye and need for protection in radiation therapy to head.

Chemotherapy — The Clinical Study of Drugs. Bull; Anderson; Mizgerd; Nuclear Medicine Clinical Unit; Meyers, Penner, Votaw, Spencer and Starkweather; Heyn.

Chemotherapy — The Development of New Drugs. Elford; Counsell and Weinhold; Goldstein; Parry; Elderfield; Ruddon; Nungester and Paradise; Duboff and Zarafonetis.

THE TUMOR REGISTRY

Begun in 1936, now directed by Robert C. H[illegible]drix, M.D., of the Department of Pathology, it is an information-retrieval project in which diagnostic data from more than 50,000 patients seen at U-M Hospital are computer-processed. The Tumor Registry participates with eight other hospitals and three state registries in The End Results Group of the National Cancer Institute.

Copies of "Cancer Research and Patient Care" may be requested from the Editorial Office, Office of Research Administration, The University of Michigan, Ann Arbor 48105, free of charge.

Michigan Leader Among States In Diabetes Detection

Since beginning its diabetes detection program, the Michigan Diabetes Association has tested nearly a million persons. Michigan is a leader among the states in diabetes detection, according to Henry D. Kaine, M.D., Detroit, in charge of the MDA Detection program.

A major breakthrough was accomplished recently by the state organization, notes Doctor Kaine, with the opening late in 1968 of a year-round detection center at the MDA office in Detroit to serve the public in the same way as chest X-ray vans do.

"We hope this will be the first of several such centers where people can come in off the street for a blood sugar test," the doctor says. He reports the center has been well received and busy though no figures are yet available on the number of persons served.

Further testing by Michigan doctors is still proceeding following the drive to find diabetics during Diabetes Detection Week Nov. 17-23 when 7,594 persons turned up for tests at 28 Michigan test sites. MDA detection trailers were stationed in Ann Arbor, Detroit and Kalamazoo.

"We are grateful to the doctors who have already followed through with persons whose tests were positive," says Doctor Kaine, "And we'd like to ask those who have not already done so to send in their responses so we can complete our data."

CPHA PUBLISHES DISEASES HANDBOOK

A two-volume "Hospital Adaptation of the International Classification of Diseases" has been published by the Commission on Professional and Hospital Activities (CPHA) at Ann Arbor. The books translate all the known diseases, injuries and operative procedures into numeric representations for research and study purposes.

Several Michigan physicians served on the research team which developed the publication.

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

OFTEN... HER LOWER G. I. TRACT



Psycho-abdominal Distress: Frequently Female

Women aged 15 to 45 appear to be more prone than men to bloating, cramping pain of stress-related intestinal disturbances such as irritable or spastic colon.[1,2]

Frequently Recurrent

In the experience of many physicians, women are more likely to reappear time after time with repeated complaints of lower G.I. distress.

Requiring Definitive Therapy

Often needed is therapy adequate to control both the somatic and the emotional components of psycho-abdominal complaints.

Definitive Dual Therapy

'Milpath' contains a proven synthetic anticholinergic useful for relieving hypermotility, spasm, and hypersecretion of the gastrointestinal tract.

In addition, 'Milpath' provides a time-tested tranquilizer for mild but effective anti-anxiety action.

With Flexible Dosage

- 'Milpath'-400 (meprobamate 400 mg. + tridihexethyl chloride 25 mg.) Usual adult dose: 1 tablet *t.i.d.* and 2 at bedtime.
- **When less tranquilization is required: 'Milpath'-200 (meprobamate 200 mg. + tridihexethyl chloride 25 mg.)**

Wallace Pharmaceuticals/ Cranbury, N. J. 08512

gently but firmly

MILPATH®

(meprobamate + tridihexethyl chloride)

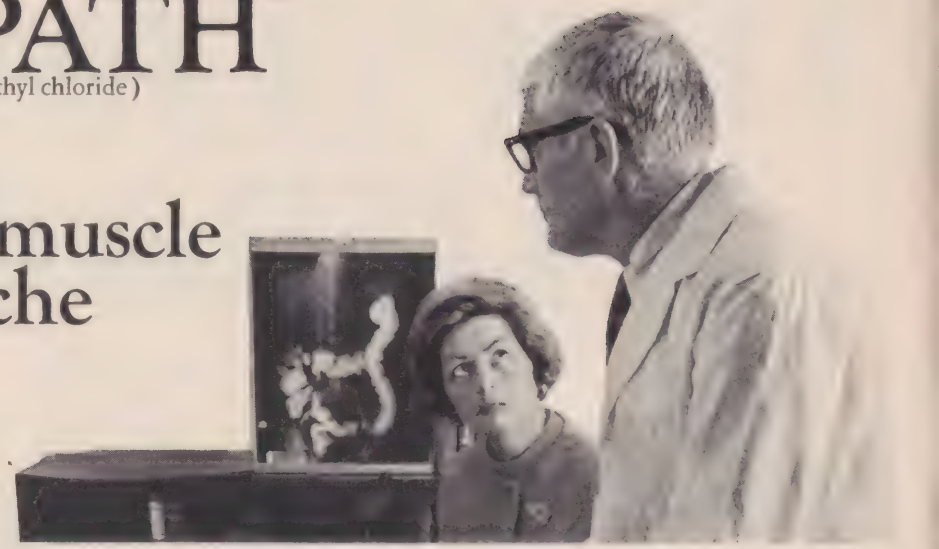
relaxes smooth muscle and psyche

Please see the following page for brief summary of prescribing information.

Gently but firmly MILPATH®

(meprobamate + tridihexethyl chloride)

Relaxes smooth muscle and psyche



Usual Adult Dosage

One 'Milpath'-400 tablet, three times a day at mealtimes, and two at bedtime. For greater anticholinergic effect, two 'Milpath'-200 tablets, three times a day at mealtimes and two at bedtime. Doses of meprobamate above 2400 mg. daily not recommended.

Indications

Useful in organic and functional disorders with hypersecretion and hypermotility of G.I. tract, especially when accompanied by anxiety, neurosis, or tension states. Should be used as an adjunct to all other therapeutic measures.

Contraindications

Tridihexethyl chloride: Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus: organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention.

Meprobamate: Previous allergic or idiosyncratic reactions to meprobamate.

Precautions

Tridihexethyl chloride: Use cautiously in elderly males (possible prostatic hypertrophy).

Meprobamate: Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (one or two weeks) after excessive dosage for weeks or months to avoid recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.

Side Effects

The following side effects of components may occur with 'Milpath'.

Tridihexethyl chloride: Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness.

Meprobamate: Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after one to four doses); in mild form: itchy, urticarial or erythematous, maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and one fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (one fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, one fatal aplastic anemia reported, but only in presence of known toxic drugs, porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by one observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported.

Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.

Supplied

In two strengths:

'Milpath'-400: Yellow, scored tablets.

'Milpath'-200: Yellow, coated tablets.

Before prescribing, consult package circular.

References

1. Harrison, T. R., et al.: Principles of Internal Medicine, Fifth Edition, New York, The Blakiston Division, McGraw-Hill Book Company, 1966, p. 1019. 2. Bockus, H. L.: Gastroenterology, Second Edition, Philadelphia & London, W. B. Saunders Company, 1964, Vol. II, p. 729 et seq.

(1928A01J)

this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase® Ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. **ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances.** In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48168

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

348-8



The go-ahead-and-enjoy-your-vacation summer cold and allergy pill.

Novahistine LP lets you provide effective relief of summer cold and allergy symptoms, lets your patients go ahead and enjoy their vacations.
These continuous-release, decongestant tablets contain a vasoconstrictor-antihistamine formulation that goes to work promptly and lasts for hours. Even the nasal congestion resulting from repeated allergic episodes can usually be relieved by Novahistine LP.

And, convenient twice-a-day dosage lets most patients enjoy relief all day and all night. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

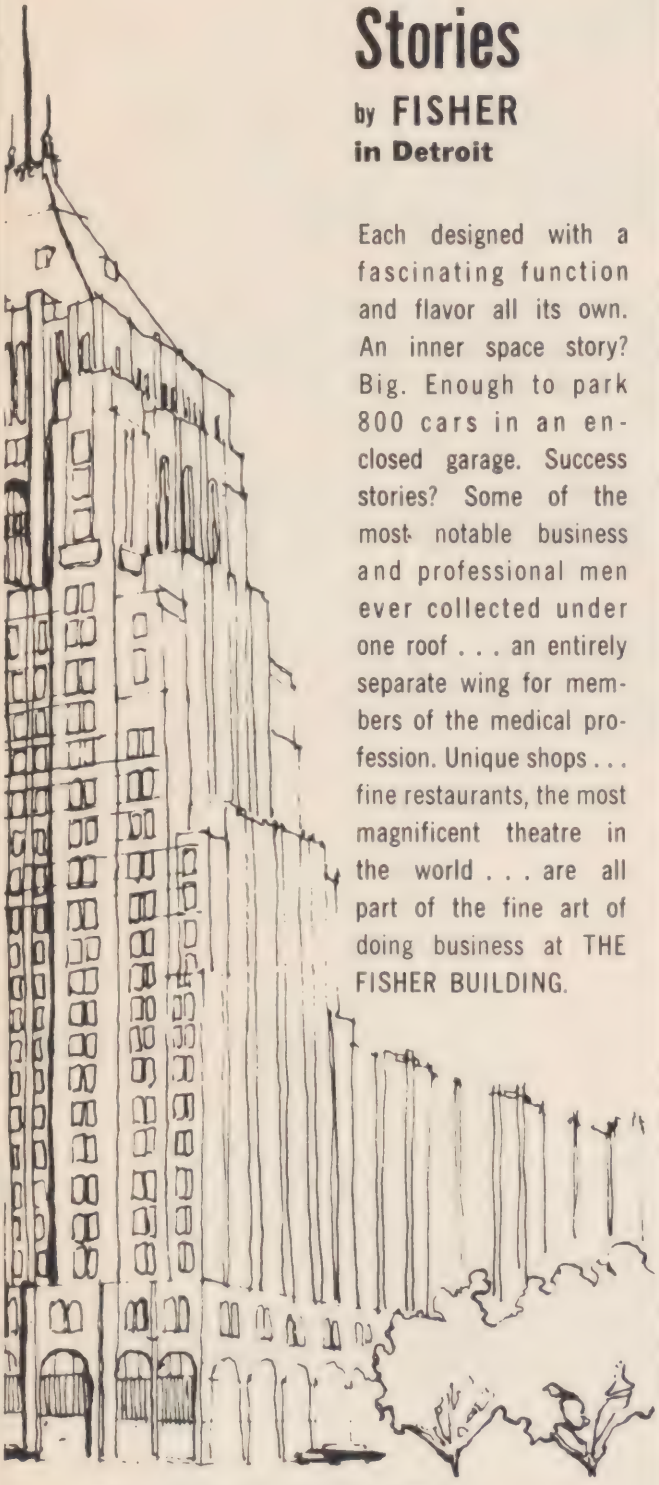
Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW

28 Tall Stories

by FISHER
in Detroit



Each designed with a fascinating function and flavor all its own. An inner space story? Big. Enough to park 800 cars in an enclosed garage. Success stories? Some of the most notable business and professional men ever collected under one roof . . . an entirely separate wing for members of the medical profession. Unique shops . . . fine restaurants, the most magnificent theatre in the world . . . are all part of the fine art of doing business at THE FISHER BUILDING.

Call or write the Rental Office

THE FISHER BUILDING

Across from the General Motors Bldg.

Detroit, Mich. 48202 (313) 874-4444



NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Huschang M. Payan, M.D., Bell Memorial Hospital, Ishpeming 49849

Phillip E. Perkins, M.D., 1414 W. Fair Avenue, Marquette 49855

Pauline Pevin, M.D., 18709 Meyers Road, Detroit 48235

Sol D. Pickard, M.D., Henry Ford Hospital, Detroit 48202

Ricardo A. Rivas, M.D., 3295 Orchard Lake Road, Orchard Lake 48033

Robert L. Roty, M.D., Matthews Bldg., Owosso 48867

Sirun Sarafoglu, M.D., Northville State Hospital, Northville 48167

Arek L. Sarkissian, M.D., 3800 Woodward Ave., Detroit 48201

Peter Slaughter, M.D., 13235 Woodrow Wilson, Detroit 48238

Michael Vulpe, M.D., Harper Hospital, Detroit 48201

Arthur W. Weaver, M.D., VA Hospital, Allen Park 48101

David K. Heaps, M.D., Univ. Medical Center, Ann Arbor 48104

Jimmy Mistry, M.D., 900 Woodward Ave., St. Joseph Hosp., Pontiac 48053

Richard P. Dorr, M.D., St. Joseph Mercy Hospital, Ann Arbor 48104

Charles R. Baber, M.D., 204 E. West St., Sturgis 49091

John G. Den Hartog, M.D., 2537 Three Mile Rd., N.W., Grand Rapids 49504

Darrel D. Domann, M.D., 906 Maybelle, N.E., Grand Rapids 49503

Max L. Durfee, M.D., 207 Fletcher, Ann Arbor 48104
Joseph W. Hance, M.D., Providence Hosp., 16001 W. 9 Mile Rd., Southfield 48075
William N. Hawks, Jr., M.D., Univ. Medical Center, Ann Arbor 48104
Verne L. Hoshal, Jr., M.D., St. Joseph Mercy Hosp., Ann Arbor 48104
Robert T. Mast, M.D., 602 N. Woodward Ave., Birmingham 48011
Parviz Meghnot, M.D., 740 Emerick, Ypsilanti 48197
Barry Miller, M.D., University Hosp., Ann Arbor 48104
James L. Werth, M.D., U. of M. Hospital, Ann Arbor 48104
Arnold H. Wexler, M.D., 2215 Fuller Rd. #105, Ann Arbor 48105
Glenn A. Zimmermann, M.D., 2871 Manitou Dr., N.E., Grand Rapids 49505
Ronald S. Bennett, M.D., 17727 W. Ten Mile Rd., Southfield 48075
Lary R. Berkower, M.D., 20905 Greenfield, Southfield 48075
Lawrence S. Bizer, M.D., 27718 Echo Valley West, Farmington 48024
Daniel R. Guyot, M.D., 3825 Brush, Detroit 48201
David M. Hirsch, Jr., M.D., VA Hospital, Allen Park 48101
Cecelia Hissong, M.D., 4407 Roemer, Dearborn 48126
James A. Krug, M.D., 32238 Schoolcraft, Livonia 48150
Lydia T. Lee, M.D., Ford Motor Co., 3001 Miller Rd., Dearborn 48120
Darlene Martenson, M.D., 3225 Ramond, Saginaw 48601
Yvan J. Silva, M.D., 3800 Woodward, Detroit 48201
Charles M. Cowan, M.D., 1400 Chrysler Expwy., Detroit 48207
Lawrence Power, M.D., 1400 Chrysler Expwy., Detroit 48207
Richard G. Quevy, M.D., 36616 Plymouth Rd., Livonia 48150
John T. Sydnor, M.D., 3800 Woodward, Detroit 48201
Burhan C. Babacan, M.D., 569 Wildwood Avenue, Jackson 49201
Edward Stehouwer, M.D., 828 Oak Street, Cadillac 49601

DOCTOR WALLS ACTIVE AT 73

Arch Walls, M.D., MSMS past president for 1956-57, is serving on the draft board in Kalispell, Mont., and is in active medical practice four to five hours a day at the age of 73. He and his wife moved to Kalispell five years ago where their son Bob is in business. Their daughter is teaching in Bloomfield Hills.

A matter of record

An electrocardiogram must be diagnostically accurate and clear in every detail, for it is a permanent record of your patient's condition. Whether it is an emergency situation or just an annual check-up the Burdick EK 4 will give you dependable, trouble-free performance and reliable diagnostic accuracy. For best performance, fidelity and definition from your cardiograph be sure to use Burdick ECG paper. For additional information write The Burdick Corporation, Milton, Wis. 53563.



BURDICK

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit, Michigan 48201
Telephone: TEmple 2-4444



ANCILLARY

STEPS TAKEN TO DEVELOP DETROIT CHP AGENCY

Michigan's Comprehensive Health Planning Commission recently recommended approval for an application by the Greater Detroit Area Hospital Council for a one-year federal grant of $207,044, beginning June 1, to develop a CHP agency for southeastern Michigan. The grant would cover Wayne, Oakland, Macomb, Washtenaw, Monroe, Livingston and St. Clair Counties.

The Commission's action sanctioned an agreement between the Southeastern Michigan Council of Governments (SEMCOG) and the United Health Organization (UHO) who agreed to have the Greater Detroit Area Hospital Council take responsibility for developing the CHP agency. A 27-member Areawide Health Operating Committee will guide the Hospital Council in the developmental activity. If the application is approved by the federal government, the task of organizing the CHP agency must be completed in January, 1970, when an application for an operational grant would be submitted.

John McCabe New National Blue Shield Treasurer

John C. McCabe, president of Michigan Blue Shield, was elected treasurer of The National Association of Blue Shield Plans at the association's 1969 annual business meeting recently. John W. Castellucci, former assistant director of Michigan Blue Shield, was re-elected president before joining the national association in 1955.

Health Council Reports Largest Registration Of New Doctors

The Michigan Health Council has reported the largest gain of new registrations of doctors in the state during the past year of any year since the Council began its M.D. Placement Service in 1955.

From April, 1967, to April, 1968, 363 M.D.s were newly registered in Michigan, compared with a gain of 47 in the previous year and 25 the year before that. Since 1961, the number of medical doctors registered in Michigan has increased from 7,431 to 8,742, a gain of 1,311 according to E. Gifford Upjohn, M.D., Kalamazoo, president of the Health Council.

Approximately half the new registrations, according to John A. Doherty, executive director of the Health Council, were new graduates from Michigan medical schools, a small percentage came from foreign countries and the remainder came from other states.

The Michigan Health Council has run full-page national advertisements in medical journals, distributed brochures on the need of doctors in Michigan and assisted several local Michigan counties in preparing their own physician-attracting campaigns. Outstanding among the latter has been the Jackson County effort. It has included cooperation between business men, the local newspaper and the Jackson County Medical Society in preparing a brochure and kit sent to hundreds of prospective doctors on the MHC mailing lists as well as to teaching hospitals.

Oakland County made the largest gain of doctors during the past year by adding 132 men to the professional force. Behind it in terms of numbers of M.D.s added were Washtenaw County with 80; Kent County, 34; Kalamazoo County, 20; Macomb County 18; Ingham County, 18; Berrien County, 10; Genesee County, 10, and Saginaw County, 9.

BEAUMONT HOSPITAL ADDITION BEGUN

Construction of a new $1 million two-story building adjoining the south wing of William Beaumont Hospital, Royal Oak, was begun this spring. The new structure will be known as the Business Services Building and will house Beaumont's computer center, a 250-seat auditorium for medical and community health educational programs, classroom facilities for employee training, laboratories for applied research, a medical photography laboratory, business offices and the hospital's print shop and personnel, purchasing and public relations departments. It is scheduled for completion by the end of this year.



BENNETT J. McCARTHY
... new Blue Shield leader



WILLIAM S. McNARY
... retiring Blue Shield head

Bennett J. McCarthy New Blue Cross President

Bennett J. McCarthy, Birmingham, an executive of 21 years' experience with Michigan Blue Cross, took the helm of the organization May 1, succeeding William S. McNary, who retired after 22 years as the Plan's chief executive.

McCarthy has been vice president and general manager of Michigan Blue Cross since July, 1964, and joined the staff in 1948 after being vice president of the Michigan Hospital Association.

Mr. McNary, also of Birmingham, resigned as executive director of the Colorado Blue Cross and Blue Shield plans in 1947 to assume the top administrative post with the Michigan Blue Cross Plan.

Under his guidance, the Plan's membership has grown more than four times its 1947 size, yet the Michigan Blue Cross operating costs are among the lowest in the country.

PROBATE COURTS, LAFAYETTE CLINIC TO WORK TOGETHER

All Michigan Probate Courts will be offered a "special diagnostic and screening service as a result of recent changes in the law effecting the Department of Mental Health program of care and treatment for persons needing hospitalization because of convulsive disorders.

This announcement by the Department in a directive said "Whenever a court is presented with a petition or request for the commitment of a person as epileptic, and the existence of a convulsive disorder is confirmed by the certifying physician or other medical opinion available to the court, the Department desires that the patient be referred to the Lafayette Clinic (Detroit) for diagnostic studies. The directive also stated "Whenever possible, such patients, upon referral by the court, should enter the Lafayette Clinic as a voluntary patient. When the voluntary procedure is not indicated, it is suggested that the court issue a temporary order."

Lafayette Clinic, under the jurisdiction of the Department, is a psychiatric and neurological research service and training facility, directed by Jacques S. Gottlieb, M.D.

This diagnostic and screening service will greatly enhance the providing of appropriate and effective care and treatment with cooperation by Probate Courts with the added benefit of the courts being supplied with an in-depth professional opinion of the patient's needs in advance of a court decision on commitments.

NEWLY-GRANTED REHAB INSTITUTE TO SERVE MICHIGAN

A grant of $100,000 has been made by HEW to the Rehabilitation Institute of Chicago and Northwestern University, the result of the two institutions' designation as the Research and Training Center in Rehabilitation Medicine for the Midwest, including Michigan.

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan — MU 5-8441

M. Leroy Barry, M.D.

Dan W. Everett, M.D.
Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

DETROIT DOCTORS PRODUCE FILM TO RECRUIT BLACK YOUTH FOR MEDICINE

"You Can Be A Doctor" is the title of a medical recruitment film produced in Detroit for Black children that has brought favorable responses in its first showings this spring.

Released April 15, 1969, by the McGraw-Hill Book Company, the film has been shown in many of the Detroit inner-city schools and is a regular part of the Detroit Medical Society's medical recruitment program. The film was made by the International Afro-American Museum, Inc. (IAM), of Detroit, and subsidized by the Detroit Medical Society.

Some groups that have seen the film recently are the Medical Manpower Section of the National Institutes of Health, the Board of Governors of Wayne State University, Booker T. Washington Business Association, the Detroit Board of Commerce, The Medical Admissions Conference in Dallas and various youth and civic groups throughout Detroit.

The film is booked this month at the American Library Association Meeting in Atlantic City.

Producers of the film are two doctors, Charles Wright, M.D., a member of the I.A.M. Board of Directors, and Charles Whitten, M.D., both Wayne State University School of Medicine professors. They have been aided by William Bentley, M.D., Detroit, Joseph Barrett, director, and Fred Schoen, script.

"We directed our film to the Black child in order to provide incentive for him to consider medicine as a profession," says Doctor Wright. "We produced a script after interviewing Black students in the effort to evaluate their knowledge of the subject, attitudes and needs. Every effort was made to involve the students in the entire effort."

"Despite the fact there has been no real effort at publicity so far, a nation-wide response to the movie seems evident," he continues.

The film is available for purchase or rental and is the first in a series of recruitment films to be made by the I.A.M. The second film, related to the banking industry, is well underway, reports Doctor Wright.

The National Institutes of Health have expressed an interest, he says, in a second medical film that would take up the theme of "You Can Be A Doctor" and carry it into the subject of academic requirements of medical school, relating them to the actual work the student does each day in school.

The present schedule for the movie is handled through the Recruitment Committee of the Detroit Medical Society, with Mrs. Milton Palmer in charge from Martin Luther King High School.

BLUE SHIELD'S TV DOCUMENTARIES AVAILABLE TO PUBLIC

A trilogy of TV documentaries on narcotic addiction sponsored by Michigan Blue Cross-Blue Shield is being made available without cost to church, school and similar groups. As each of the three films is shown on television, it becomes available for public use. The second was aired in mid-April over Detroit and Grand Rapids stations.

Those interested may contact William DeGrace, Public Relations Department No. 54, Michigan Blue Shield, 441 E. Jefferson, Detroit 48226, or Rexford Randall, Manager, Michigan Blue Cross and Michigan Blue Shield, 2422 Burton, S.E. Grand Rapids 49506.

Insurance Rating Board Releases Liability Premiums

The Insurance Rating Board recently released a list of the professional liability premiums, $5,000/$15,000 basic coverage for a class V surgeon, single coverage for basic limits.

California tops the list at $925, followed by Arizona and Nevada at $610 each and New York at $600.

Thirteen other states are above the Michigan rate of $295.

The rates for Midwest states included $235 in Illinois, $260 in Indiana, $340 in Ohio, $270 in Wisconsin, $212 in Minnesota.

A physician in California, who performs general surgery, pays over $2,000 premium annually for 100/300 coverage.



For the "Cheater Eater"

Formulas: Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid (Warning, may be habit forming). Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital (Warning, may be habit forming).
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
Supplied: In bottles of 50.

Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

Spansule®

brand of sustained release capsules

curbs appetite
encourages normal activity
dispels diet discouragement

SK&F
Smith Kline & French Laboratories

Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

EQUANIL®
(meprobamate)

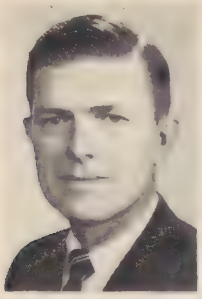
Wyeth

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.



DOCTOR BLOCK NEW IMA PRESIDENT



DUANE L. BLOCK

Duane L. Block, M.D., Dearborn, has begun his term as president of the Industrial Medical Association (IMA), international society of physicians in industry.

He is physician-in-charge of the Ford Motor Company's Rouge Medical Service, and also holds appointments as clinical assistant professor, Department of Environmental and Occupational Health, Wayne State University, and as non-resident lecturer in occupational medicine at the University of Michigan School of Public Health.

Now acting as secretary for the IMA is William Jend, Jr., M.D., Detroit, medical director of Michigan Bell Telephone Company. The Michigan doctors took their positions at the association's 54th annual meeting in late April at Houston, Tex.

MSPA FORMS COUNCIL ON DRUG ADDICTION

Michigan State Pharmaceutical Association executive Director Robert C. Johnson has announced the formation of the coordinating Interprofessional Council on drug Addiction, Referral and Education (I-CARE).

Project CARE is being initiated as a forum for drug education programs in Michigan, and to stimulate innovative activities associated with drug dependencies and addiction.

Project CARE will be a voluntary agency composed of pharmacists and other health and non-health professional persons who have acquired extensive understanding and knowledge of today's drug abuse problem. The Council membership will function to guide the activities of Project CARE in such areas as literature review and the publication of abstracts, sponsorship of state and regional conferences, and the development of an experimental counseling and referral center and related community service programs.

Project CARE will convene an organizational session on June 25 in conjunction with the MSPA Annual Meeting on Mackinac Island.

Corticosteroid Injection Techniques on New Film

The technique of intra-articular and peri-articular injection of corticosteroid in treating arthritic patients is shown in a new film, eighth in the award-winning Vanguard of Medicine series produced by The Upjohn Company. The film is available without charge to members of the medical and related professions from The Upjohn Professional Film Library, Kalamazoo.

AMA-NEA Joint Committee Adopts Seven Resolutions

Seven new resolutions have been adopted by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, which held its annual meeting recently.

They are:

(1) That the 1964 and the 1965 Joint Committee resolutions "Schools and Problems Related to Sex" and "Orientation of Physicians: Sex Education of Patients" with all their concepts and purposes be reaffirmed; and that the counsel and support of appropriate school-community advisory groups be sought so that such programs will meet the unique needs of the children in each community.

(2) That states not having separate certification of teachers of health, institute such regulations at the earliest possible time and that certification provisions for teachers of health include the requirement of at least a minor and wherever possible a major in health.

(3) That state and community councils and committees on comprehensive health planning include health education among their considerations along with health facilities, manpower, and health services, and that representative health educators be included among the personnel involved in councils and committees on comprehensive health planning.

(4) That teacher preparation in health education for both the elementary and secondary level give special consideration and emphasis to the professional preparation needed for effective teaching of all students.

(5) That the staffs of the parent organizations study the problem of accident insurance in the schools being sold or provided for pupil coverage and report on its status at the next meeting of the Joint Committee.

(6) That those involved in health manpower planning, wherever possible establish programs that encourage an individual in one health category to advance to another if he/she is so motivated, and that built-in incentives be incorporated, as rapidly as possible, in health career education programs so that individuals will be encouraged to start in one health career category with the hope and expectation of being able to continue to advance themselves as circumstances permit.

(7) That physicians and educators in each community jointly study the health aspects of this development and make recommendations to assist in coping with student unrest and the problems it creates.

IN MEMORIAM

Archie A. Bedell, M.D.
Detroit

Archie A. Bedell, M.D., Detroit general practitioner, died April 4 at the age of 64.

Doctor Bedell was affiliated with Saratoga General Hospital in Detroit and was graduated from the Wayne State University Colloge of Medicine. He was also a member of the Michigan Association of the Professions.

Lewis F. Brown, M.D.
Otsego

Lewis F. Brown, M.D., life-long Otsego resident and general practitioner there, died March 28 at the age of 66.

Doctor Brown, who specialized in anesthesiology, was graduated from the Wayne State University College of Medicine and was affiliated with William Crispe Hospital in Plainwell. He had been chief of Pipp Community Hospital in Plainwell.

He was a member of the American Society of Anesthesiologists and had been treasurer of the Allegan County Medical Society and a member of the MSMS House of Delegates.

Frederick J. Cady, M.D.
Saginaw

Frederick J. Cady, M.D., Saginaw otolaryngologist for 47 years, died March 24 in Green Valley, Ariz., at the age of 78. He had retired in 1966.

Doctor Cady was a former president of the Saginaw County Medical Society and was former chief of staff of St. Mary's Hospital in Saginaw. He was a member of the American College of Surgeons, American Board of Ophthalmology, American Board of Otolaryngology and the American and Saginaw Valley Academies of Ophthalmology and Otolaryngology.

He had also served on medical staffs at Saginaw General and St. Luke's Hospitals and was a graduate of the University of Michigan Medical School.

Wilfrid Cowan, M.D.
Detroit

Wilfrid Cowan, M.D., Detroit practitioner for 45 years, died April 12 at the age of 74.

Doctor Cowan, a graduate of the Detroit College of Medicine, was on the staff of Hutzel Hospital more than 30 years and was a life member of the Wayne County Medical Society. He was house doctor at Cottage Hospital in Grosse Pointe Farms.

David Lessem, M.D.
Huntington Woods

David Lessem, M.D., Huntington Woods, died March 26 at the age of 50.

Doctor Lessem, a psychiatrist with an American Board Certification in psychiatry and neurology, practiced in Detroit. He was a graduate of the Wayne State University Medical School and was affiliated with Glen Eden Hospital in Warren and Hutzel Hospital in Detroit. He was a member of the American Psychologists Association and the Michigan Association of the Professions.

Dorman E. Lichty, M.D.
Ann Arbor

Dorman E. Lichty, M.D., Ann Arbor pediatrician for 30 years, died March 25 at the age of 63.

Doctor Lichty was a graduate of the University of Michigan Medical School and taught pediatrics there. He was also associated with Dearborn's Wyoming Clinic. He was a member of the American Academy of Pediatrics.

Wilbur Chapman Medill, M.D.
Plainwell

Wilbur Chapman Medill, M.D., long-time Plainwell general practitioner who specialized in surgery, died March 8 at the age of 77.

Doctor Medill, a graduate of Columbia University, was affiliated with William Crispe Hospital in Plainwell and the Allegan Health Center in Allegan. He was a Fellow of the American Society of Abdominal Surgeons, a Fellow of the International Academy of Proctology, a member of the American Academy of General Practice and a life member of the Postgraduate Medical Assembly.

He was twice president of the Allegan County Medical Society.

Howard Carl Rees, M.D.
Detroit

Howard C. Rees, M.D., long-time Detroit general practitioner, died April 10 at the age of 70.

Doctor Rees was graduated from the University of Michigan Medical School and was a staff member of Grace Hospital. He was a past president of the Wayne County Academy of General Practice and was a charter member of the American Academy of General Practice.

Doctor Rees was a delegate to MSMS from Wayne County and served on the early Medical Advisory Committee to Blue Shield.

Fred M. Slaughter, M.D.
Detroit

Fred Milton Slaughter, M.D., Detroit general practitioner, died March 29 at the age of 78.

Former administrator of St. Louis City Hospital and Detroit's Parkside Hospital, Doctor Slaughter was a graduate of Temple University Medical School. He was a trustee of Parkside from 1947 until his death and was also affiliated with Burton Mercy Hospital of Detroit.

Doctor Burton was a member of the American Academy of General Practice and the Detroit Medical Society.

(Continued on Page 658)



COUNTY SOCIETIES

YMCA Favorite with Genesee Doctors

Many Genesee County Medical Society members make a regular practice of recreation at the YMCA on Wednesday and Saturday afternoons. Among those seen on the popular paddle ball courts there are Richard C. Gumpper, M.D., Paul E. Schroeder, M.D., Eugene C. Smith, M.D., J. J. Gutow, M.D., and Bernard J. Harris, M.D.

Macomb MD's Hear Cancer Talk

Members of the Macomb County Medical Society heard a talk on "Some Broad Aspects of Cancer Treatment" at their April meeting. Speaker was James J. Humes, M.D., pathologist at St. John Hospital in Detroit.

IN MEMORIAM/Continued

Franklin W. Smith, M.D.
St. Johns

Franklin W. Smith, M.D., St. Johns, former director of the Mid-Michigan District Health Department, died March 29 at the age of 53.

Doctor Smith, general practitioner in the Owosso-St. Johns-Ovid area for many years, was on leave from the district health department to work on a master's degree in public health administration. He was a graduate of the University of Michigan Medical School and was affiliated with Clinton Memorial Hospital in St. Johns.

He had been a member of the MSMS House of Delegates and a former president of the Clinton County Medical Society.

Richard W. Traicoff, M.D.
Pontiac

Richard W. Traicoff, M.D., Pontiac intern, died April 1 at the age of 27. Doctor Traicoff was a graduate of Wayne State University School of Medicine and was a member of Wayne County and Oakland County Medical Societies and the Michigan State Medical Society.

Washtenaw Meetings Have Variety

At recent general sessions of the Washtenaw County Medical Society, members have been treated to a visit by a well-known college athlete, a talk on the physician's role in treating the alcoholic and a report on a trip by local physicians to Guam. The athlete was Ron Johnson, University of Michigan football star; the speaker on treating the alcoholic was Ralph Daniels of the Washtenaw County Council on Alcoholic Problems and the Guam reporter was R. Craig Barlow, M.D., Ann Arbor, a member of the Washtenaw Society and leader of the expedition who illustrated his story with slides. (An account by Doctor Barlow of the Guam trip appeared in the May issue of *Michigan Medicine.*

Oakland Sponsors Pre-Natal Classes

The Oakland County Medical Society has been co-sponsor for three series of eight classes for expectant parents offered in recent months by the Oakland County Health Department. The most recent series of classes, taught by public health nurses, concluded in mid-May.

North Central Screen-Tests Adults

Screening tests to discover hidden chronic illness among apparently well adults were offered in April and May to residents of Roscommon County. Sponsoring the tests, which were administered from mobile units, were the Roscommon County Health Department and the Medical Society of North Central Counties.

Kalamazoo Members Hear Georgetown Doctor

Christopher M. Martin, M.D., director, Laboratory of Clinical Pharmacology, Georgetown University School of Medicine and director, Georgetown Medical Division, District of Columbia General Hospital, was the speaker at the April meeting of the Kalamazoo Academy of Medicine. Doctor Martin discussed "The Therapy of Gram-Negative Sepsis: Results of Two Controlled Trials."

Bay Supports School Physician Plan

The Bay-Arenac-Iosco County Medical Society has expressed its support of the idea of designating a Doctor of Medicine to the position of physician to each of the many school systems in Bay County and urges that each school system, as well as parochial grade and high schools take the action. Designating school system physicians would be part of a program to set communal school health standards and aid in making these services available to each student through a personal physician or through the supervision of a doctor employed by the system so to act.

Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

WANTED: Physician to work as a partner in a thriving community in southern Michigan. Present hospital is in the process of being enlarged. The medical offices are in the hospital building. Exceptional opportunity for the right man interested in general practice. He should be competent to do general surgery. A Locum tenens is greatly needed during the summer months to relieve the present physician after a long hard winter's work. Contact: B. H. Growt, M.D., Medical Center, Addison, Michigan 49220.

MEDICAL DIRECTOR: For well established Health Department in Allegan County, Allegan, Michigan, serving 60,000 population. Requires: M.D. Salary commensurate with experience. Benefits: Paid vacation, holidays, sick leave and retirement program. Please write: John Pahl, Acting Director, Allegan County Health Department, Allegan, Michigan 49010.

ALPENA, MICHIGAN — Middle aged Generalist with General, Gynecological and Traumatic Surgical practice retiring due to failing health. $40M to $60M gross annually prior to restriction of activities. Excellent opportunity for a Generalist with two years Residency in General Surgery or Gynecology. Modern office building one block from center of city, complete with office equipment and clinical lab., excellent office staff; office and in-hospital surgical instruments. 200 bed modern Accredited Hospital. Complete records for 29 years. Will rent, lease, or sell building and equipment; will introduce and help in obtaining staff appointment. Will assist in financing. This is not an opportunity for a Generalist without special training as outlined above. Contact: John W. Bunting, M.D., 110 N. First St., Alpena, Michigan.

FOR RENT: Medical suite modern air conditioned, part of Medical-Dental building in Dearborn. Excellent location. Call or write: Francis A. Lutone, D.D.S., 23401 Ford Road, Dearborn, Michigan 48128. Phone (313) LOgan 1-3367.

LAKE MICHIGAN FRONTAGE. Upper Peninsula, one hour from Mackinac bridge. Sand beach. Inside Mackinac State Forest, 86.35 acres, road into tract. Investment opportunity for long range appreciation plus interim recreational use. VACATIONLAND REALTY, 509 Northland Towers West, Southfield, Michigan 48075. (313) 357-0906.

MEDICAL DIRECTOR — Single County Health Department; with 40 employees, population 165,000. VD, TB, and general health programs. Good relations with local physicians. Excellent recreational and school facilities. If under age 50 require MD or DO degree and obtain MPH within 3 years with state assistance. Over age 50, require 9 weeks of special courses over 3 years in lieu of MPH. Salary range $23,000 to $27,500. Starting rate depends on qualifications and experience. Usual fringe benefits. Send application and resume to Acting Director, James V. Wells, Muskegon County Health Department, County Building, Muskegon, Michigan 49440.

PSYCHIATRIC RESIDENCIES: Approved three-year community oriented dynamic program in Metropolitan Detroit area. University associations. Teaching staff of Board men, psychoanalysts, professors, outstanding visiting lecturers. Active research. Modern physical plant. Salary $9,875; $10,445; $11,234. Five year career program $11,234 to $20,357. Liberal Civil Service benefits. Write: Director of Education and Research, Northville State Hospital, Northville, Michigan 48167.

SMALL COMMUNITY in resort area of Southern Michigan needs GP's, Pediatricians and Internist. No big city problems. Solo or potential group practice available. Fully accredited 102 bed hospital with ICCU. Ideal family community. Contact Larry T. Burch, M.D., 10 Cairns Street, Tecumseh, Michigan 49286.

GENERALISTS AND PSYCHIATRISTS — In accredited progressive 2000 bed mental hospital with approved psychiatric residency training program. Ideal living in active resort community located in Michigan's serene, scenic water-wonderland. Salary $22,550-$30,464, depending on qualifications. (Salary rates effective July 1, 1969) Unparalleled retirement and fringe benefits. Contact M. Duane Sommerness, M.D., Superintendent, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

UROLOGIST needed to join established multi-specialty group in Detroit. Excellent professional relationships. Guarantee $25,000 minimum, plus bonuses. Reply: Box 4, 120 W. Saginaw Street, East Lansing, Michigan 48823.

FOR SALE: Combined house-office — Internal Medicine practice. House, four bed rooms, two baths, kitchen, living and dining rooms. Office — waiting room, business office, consultation and two examining rooms, laboratory, stool, storage. Central air conditioning, two car garage. Independent real estate appraisal $44,000. 1968 Gross $75,000 plus. Total sale price $35,000 cash. Financial and professional references required. Available June 30, 1969. Reply: T. Holaly, Genesee Towers, Flint, Michigan (313) 767-6702.

PSYCHIATRIC RESIDENCIES: We offer nothing but excellent psychiatric training in a stimulating, well organized program located in a culturally advantaged community. Approved psychiatric training. Traverse City State Hospital, Michigan Department of Mental Health. Three and five year programs. Salary, 3 year program: $10,669; $11,191; $12,131. Five year program: $12,152; $14,031; $16,328; $21,994; $23,093. MIMH-GP stipends available. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. Contact Dr. Paul E. Kauffman, Director of Training, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

OPHTHALMOLOGISTS: Going into smaller office. Will dispose of first class equipment including: Green Refractor + cylinder type. 2 B & L chairs with stands combined, 2 poser slit lamps, 2 perimeters — large and portable, 2 hydraulic treatment chairs, 1 trial lens set, many tables and misc. equipment including fine surgical instruments. Reply Box 5, 120 West Saginaw Street, East Lansing, Michigan 48823.

PEDIATRICIAN needed for a new agency for the mentally retarded located in suburbia between Ann Arbor and Detroit. Must be progressive in his thinking and have a desire to participate in clinical investigation. An on-going research program in genetics exists with many opportunities to consult and work with physicians from nearby universities. Must be board certified or board eligible in pediatrics and eligible for Michigan licensure in medicine. Annual Salary $20,796 - $27,290 (effective July 1, 1969) depending on education and experience. All Michigan Civil Service Benefits. For further information contact Chief of Medicine, Plymouth State Home, Northville, Michigan. An equal opportunity employer.

OBSTETRICIAN - GYNECOLOGIST to associate with young certified O.B. Multi-specialty group of six forming. Brand new hospital. Michigan Thumb recreation area. $22,000 first year, then full partnership. James M. Mullaney, M.D., 206 N. Heisterman, Bad Axe, Michigan 48413 (517) 269-7409.

GENERAL PRACTICE — MICHIGAN CENTER, MICHIGAN. Established 23 years, centrally located, four lane avenue, suburban Jackson. Two open staff hospitals 5 miles, available August. Lease, fully equipped with option to buy. Daniel Landron, M.D., 4633 Page Avenue, Michigan Center, Michigan 49254. Phone (517) 764-3720.

MEDICAL TECHNOLOGISTS: Also Histo-Technologists ASCP registered or eligible. Modern clinical laboratory. Starting salary $636 per month with increases to $760 per month. A shift differential is paid for afternoon and night shifts. Excellent fringe benefits include tuition reimbursement, paid vacations, insurance and holidays. Write or call collect (517) 487-6111 Edward W. Sparrow Hospital, Personnel Department, 1215 E. Michigan Avenue, Lansing, Michigan 48912.

MULTI-DOCTOR well established industrial clinic seeks physician interested in the office treatment of trauma and in Workmen's Compensation cases for new suburban branch. Remuneration highly competitive, fringe benefits, regular hours. Michigan license necessary. We are looking for a permanent associate. Send resume to: Robert R. Silver, M.D., 60 W. Hancock, Detroit, Michigan 48201 or call collect: (313) TE 1-3130.

WANTED: Full-time Emergency Room Physician (s) to join a four man group in a 300 bed hospital; preferably under 40; Michigan license required. Salary $30,000 annually; 48 hour week, rotating hours and weekends. Address inquiries to: G. Petropoulos, M.D., Annapolis Hospital, Wayne, Michigan.

DOCTOR ASSOCIATE wanted, good opportunity, town of 10,000 with drawing of 30,000. Write Box number 6, 120 West Saginaw Street, East Lansing, Michigan 48823.

FOR SALE:

1. Microtone, factory reconditioned, best offer.
2. Blendtone, used, best offer.
3. Burroughs Medical Office Bookkeeping Machine, series 100, used, excellent condition, best offer. Phone: Charlotte, (517) 543-3200.

Index to Advertisers

They Help Make Michigan Medicine Possible

Abbott 596, 597, 598

Brown Pharmaceuticals 569

Burroughs-Wellcome 591

Classified Advertising 659, 660

Fisher Building 648

Geigy Pharmaceuticals 564, 565, 634, 635, 636

Harcliffe Laboratories 562

Hynson, Westcott & Dunnings, Inc. ..... Cover II

Ingram, G. A. Co. 649, 661

Lederle Laboratories 560, 568, 599, 603, 633, 645

Lilly, Eli & Co. 570

Mallard, Inc. 615, 616

Medical Protective 610

Merck Sharp & Dohme 607, 608

Mercywood Hospital 569

Parke-Davis & Co. 611, 643

Pitman-Moore Div. 646, 647

Plainwell Sanitarium 651

Purdue Frederick 609

Robins, A. H. & Co. 594

Roche Laboratories ..... 592, 593, 626, 627, Cover IV

Rorer, Inc. 631

Searle, G. D. & Co. 612, 613

Smith Kline & French Labs 653

Stratton, Ben P. ..... Cover III

Stuart 644

Wallace 640, 641, 642

Winthrop Labs 614

Wyeth Laboratories 654, 655

INGRAM'S SERVICE DEPARTMENT

ALL FACTORY TRAINED MEN

We service Medical Equipment, Electrocardiographs, Basal Metabalors, Sterilizers, Autoclaves, Diathermy Outfits, Cutting Units, Ultra Violet Lamps, Hydro Therapy Units, Laboratory Equipment. ALL BURDICK, LIEBEL FLARSHEIM AND RITTER EQUIPMENT.

If you have any Service problems, please call us at TE 2-4444, ask for the SERVICE DEPARTMENT and we will gladly help in any way we can.

THE G. A. INGRAM COMPANY

4444 Woodward Avenue **TEmple 2-4444** **Detroit, Michigan 48201**

NOTES & QUOTES

BY HERB AUER, EXECUTIVE EDITOR

In 1958, 55% of males smoked; now it's 40%.

This means that ten years ago, the smoking male was in the majority, now he's in the minority.

* * *

"One hospital in five assigns an MD to the recovery room according to a survey reported in a recent issue of *Hospital Topics*. Ten per cent of the 440 reporting hospitals had full-time MD staffing of the recovery room and an additional 10 per cent had part-time MD staffing.

* * *

Many doctors, like other men, enjoy presiding at the barbecue grill during the summer. Research by the Weber-Stephen Products Company reports that "there is evidence that charcoal was used before 4,000 B.C. and that the word comes from the Anglo-Saxon word "cearcian" which means "to crackle." Henry Ford is credited with finding a way



to make charcoal into briquets for even burning for industrial purposes. Now, backyard picnics use 200,000 tons of charcoal, compared to 150,000 tons used by U.S. industry.

* * *

All incoming freshmen and transfer students at the University of Michigan will be given a 15-page booklet "About Drugs" at summer and fall orientations this year. The booklet includes information on the medical uses and the effects on mind and body of narcotics, barbituates, stimulants, hallucinogens, marijuana, and alcohol, as well as sections on legal aspects of drug use and where to go for help. The booklet was written by the U-M Student Affairs Counseling staff.

* * *

The American Social Health Association Newsletter, Vol. III, No. VI, provides some statistics from the 1969 National Survey of VD Incidence. Michigan ranks first in the number of cases of infectious syphilis per 100,000 population with 57.5 and ranks third behind Missouri and Illinois in gonorrhea with 764.4. In the same two statistical studies Detroit is second behind Cleveland in infectious syphilis with 276.6 and second behind Chicago in gonorrhea with 2308.3.

* * *

Nearly all college students in Michigan "attend classes, study hard and strive intelligently for degrees because they know the worth of what they are doing," writes W. Sprague Holden in a recent issue of the *Michigan Publisher*.

WSU Journalism Department Chairman Sprague continues: "They do not want to tear down and destroy. They want to build the future securely. They want to protect and improve our society. All this, despite the fierce proclamations of the nihilists."

* * *

"The university's influence is best utilized when it remains institutionally neutral in the normal clashes of varied community interests. From this stance, the university protects the freedom of its students and faculty in acting as individuals while remaining a common rallying point for all groups. By establishing community-wide acceptance of institutional integrity and good faith, it strengthens its role for harmonization of conflicting forces for constructive social progress."

So writes David D. Henry, president of the University of Illinois and former WSU president, in the current issue of the *WSU Graduate Comment* magazine. His article presents his views about "Education for Relevance."

* * *

A study at Syracuse University of brainmanship reveals, as you may already know, that "if you admit defeat readily, you may not



be using your assets to the best advantage." Researchers contend that a person's failings do not necessarily keep him from getting ahead, but his inability to deal with his failings can be a major hindrance.

* * *

Allen Dighera, president of the National Community School Education Association, and Consultant to the Adult Education Department of the Michigan State Department of Education, contends adult education needs are not adequately met in Michigan. He states that a minimum of 59 percent of Michigan's population has not graduated from high school.

* * *

The printers and staff for **Michigan Medicine** check and double check all copy and proofs carefully to avoid errors — but an occasional error does sneak into print. Editor Bob Pearcy of the **Danville, Indiana Gazette**, explains such errors this way: "We try to put out a paper for everyone and for those who look for mistakes we put in some so they won't be disappointed."

YOU ARE ENTITLED

TO COMPLETE SERVICE CONCERNING ANY OF THE

INSURANCE PLANS SPONSORED AND ENDORSED

BY THE

MICHIGAN STATE MEDICAL SOCIETY

Group Term Life

Group Long Term Disability

Professional Overhead Expense

Accidental Death And Dismemberment

Accident & Sickness Plan For Your Employees

The Ben P. Stratton Agency, Inc. also provides complete insurance service for Professional Corporations, Partnerships, or Individuals. Your inquiries concerning valuable fringe benefits are invited. Professional Liability insurance is also available.

Call collect, or write —

BEN P. STRATTON AGENCY, INC.

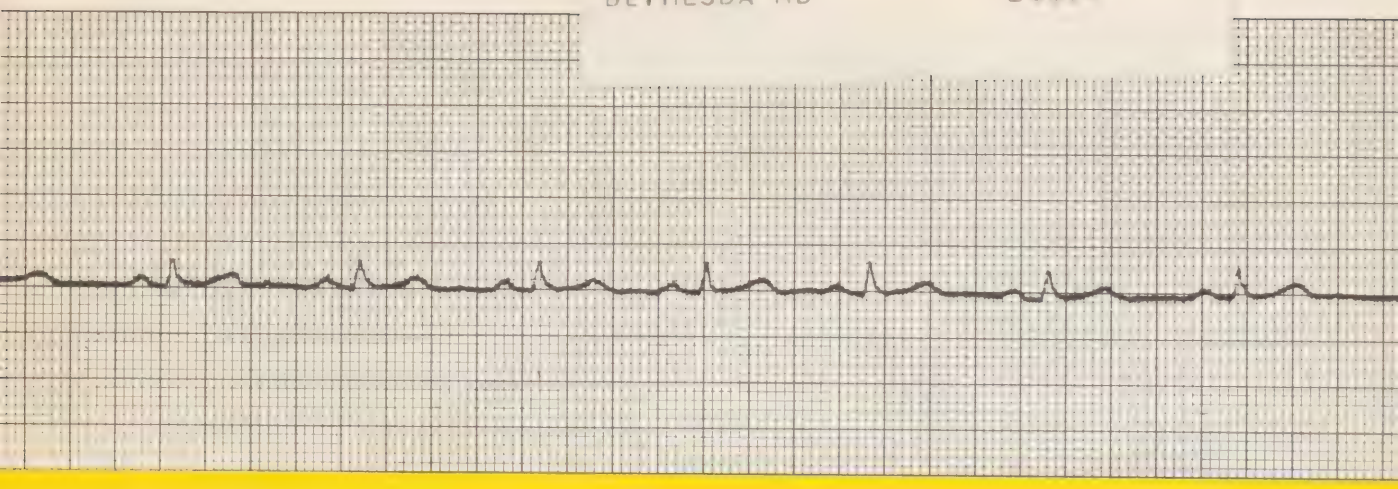
MSMS Insurance Administrators

P. O. Box 547, Lansing, Michigan 48903

Telephone: (517) 484-2578

Return Postage Guaranteed
MICHIGAN STATE MEDICAL SOCIETY
20 W. Saginaw
East Lansing, Michigan 48823

NATL INST OF HEALTH
LIBRARY
BETHESDA MD 20014



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

WI
MI225
K
Q JTC: MX2
INCOMING:
DUE-IN: 6-12
DATE:
DATE:
DATE:
RUSH:
NATIONAL LIBRARY OF MEDICINE
REC · JUL 10 1969
INDEX

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

JUNE 1969 • VOLUME 68 • NUMBER 12

SEE CENTER PAGES FOR REPORT ON OSTEOPATHIC SCHOOL BILLS

Full and Varied Program Taking Shape For Annual Session Sept. 28-Oct. 2

Plans for the 1969 Annual Scientific Session of the Michigan State Medical Society are well underway, with members of the Annual Session Program Committee making many arrangements for the Sept. 28-Oct. 2 event in Detroit.

The five-day program is to be staged at the Sheraton-Cadillac Hotel in downtown Detroit, beginning with the annual House of Delegates meeting, which regularly commences at 8 p.m. Sunday and concludes Tuesday evening following the election of new officers.

Highlights of the Scientific Session on Wednesday and Thursday will be eight general session discussions on a variety of medical subjects and two special offerings on the current controversies in marijuana and heart transplants. New ideas include a possible "moot court" — to help MDs become expert witnesses, and a State Society Dinner Dance Wednesday evening.

Running simultaneously with the Scientific Session will be four all-day Postgraduate Courses limited in attendance and only open by separate registration. They will be held at the nearby Statler Hilton Hotel.

Topics of the four Postgraduate Courses will be Cardiology, with Park W. Willis, III, M.D., and Richard D. Judge, M.D., Ann Arbor; Medical and Surgical Emergencies, with Lawrence H. Power, M.D., and Irwin K. Rosenberg, M.D., Detroit; Office Orthopedics, with Robert H. Ramsey, M.D., of Dearborn, and Renal Diseases with Clarence E. Rupe, M.D., Detroit.

General Session topics will include Surgically Correctable Forms of Hypertension, Subcutaneous Mastectomy with Prosthetic Reconstruction, a Panel on Pediatrics, The Efficient Use of Blood and Blood Components, Oxygen—Is It Necessary? Septic Abortion with Endotoxin Shock, Surgery and Diabetes.

New developments in the practice of cancer, hematology, allergy, gastro-intestinal diseases, infections and antibiotics, rheumatology, pediatrics, diabetes, and obstetrics and gynecology will be reported.



Among outstanding speakers who will appear are Albert Sjoerdsma, M.D., Ph.D., chief, Experimental Therapeutics Branch, National Heart Institute; Frank Chappel, Director of Medical Information at The University of Texas Southwestern Medical School; Leonard Graciani, M.D., Philadelphia, Pa.; Denis Cavanagh, M.D., professor and chairman of the Department of Obstetrics-Gynecology at St. Louis University; Paul Unger, M.D., professor of medicine at Southwestern Medical School and VA Hospital in Dallas, and George C. Cotzias, M.D., of Brookhaven National Laboratory.

The Woman's Auxiliary to the Michigan State Medical Society also plans its annual meeting on Tuesday-Thursday, Sept. 30-Oct. 2, in conjunction with the Annual Session.

SEE BACK PAGE FOR MORE ON ANNUAL SESSION

Doctor Swartz Appointed To New AMA Committee

Frederick C. Swartz, M.D., Lansing, has been appointed a member of the AMA's new Committee to Study Health Care for the Poor. Doctor Swartz has been chairman for 10 years of the AMA Subcommittee on Aging of the Committee on Community Health.



Doctor Swartz

Doctor Swartz will bring to the new committee 15 years of work in the field of health care for the aging population and his extensive experience and association with governmental departments and national agencies.

He is one of three from the AMA's Council on Medical Services appointed to the 11-member Committee to Study Health Care for the Poor. Chairman is Robert C. Long, M.D., Louisville, Ky.

According to AMA staff member Emory Bullis of the executive vice president's office, the new committee will be a broad policy-making group to study new approaches to resolving the health care problems of the poor.

MSMS has already initiated work in the field of health care for the poor.

As a result of MSMS leadership attending various conferences concerned with the inner-city, a Committee to Study the Disadvantaged in the Cities was appointed, with Frank Walker, II, M.D., Grosse Pointe Park, as chairman.

Since then, informal meetings with various federal and state agencies have been held in order to determine the most appropriate method of identifying the people in need of medical attention, the available resources and the additional resources needed in order to provide high quality medical care.

SUMMER SCHEDULE FOR HEALTH CAREERSMOBILE

The Michigan Health Council's Health Careersmobile is scheduled to visit Michigan cities nearly every week of the summer and well into September. The itinerary for its recent and forthcoming travels reads as follows:

June 2-6 — Detroit's Northwestern High School

June 10-13 — Macomb County Community College, South Campus in Warren

June 16-20 — Macomb Mall, Mt. Clemens, for the Macomb County Services Week

June 23 — Open

July 3-6 — Lake Odessa Fair

July 12-19 — Saranac Centennial

July 22-26 — Greenville Fair

August 1-10 — Ionia Free Fair

August 11-14 — Lapeer Days, Lapeer

August 18-23 — Calhoun County Fair, Marshall

August 28-Sept. 1 — Oceana County Fair, Hart

Sept. 6-13 — Allegan County Fair

MSU Medical Alumni Elect First Officers

Officers of the newly formed Michigan State University Medical Alumni Association are Lance E. Olson, president; Dr. Arno W. Weiss of Saginaw, vice-president, and Charles Sander, M.D., assistant professor of pathology, secretary. The association is composed of medical students who are transferring from MSU this year and medical doctors who studied for graduate or undergraduate degrees at Michigan State.

PLASTIC SURGERY ACADEMY SETS ANNUAL MEETING

The Michigan Academy of Plastic Surgery plans its summer meeting July 28-30 on Mackinac Island, with a series of talks by outstanding plastic surgeons from throughout the United States. In addition, a banquet dinner honoring Wallace Steffensen, M.D., Grand Rapids, will be given.

Doctor Steffensen, a private practitioner, will be presented with a plaque marking his many years of outstanding work in the field of plastic surgery in Michigan.

PEDIATRICIANS SOUGHT FOR CORNELL INSTITUTES

New York Hospital-Cornell Medical Center in New York City is sponsoring a series of five institutes during the 1969-70 academic year for pediatrician-nurse teams in the care of premature and other high-risk infants.

The institutes are designed for two-man teams consisting of a pediatrician and a registered professional nurse who will work together, either in starting a program of care for premature and other high-risk infants in their hospital or in an already established program in their hospital.

Registrations must be submitted to the Michigan Department of Public Health and sent on to Cornell at least three months prior to the session the applicant wishes to attend. Nurses attend a full month's seminar, physicians just two weeks of each period.

Interested physicians should address inquiries to Theresa B. Haddy, M.D., chief, Division of Child Health, Bureau of Maternal and Child Health.

MICHIGAN EMERGENCY MD's TO ORGANIZE

An organizational meeting of the Michigan segment of the American College of Emergency Physicians is scheduled at 7 p.m. June 26 at MSMS headquarters. An invitation is extended to all ACEP members and other emergency room physicians interested in attending.

Organizing the Michigan group is Gaius Clark, M.D., East Lansing, who is Michigan representative to the ACEP. Any interested doctors wishing further information should contact the Executive Secretary, American College of Emergency Physicians, 120 W. Saginaw, East Lansing 48823.

DETROIT SINAI SETS HORMONE SYMPOSIUM

"The Action of Hormones: Genes to Population" is the topic of a symposium scheduled June 30 - July 2 at Sinai Hospital of Detroit by the hospital's division of research, in collaboration with the Wayne State University School of Medicine and the Michigan Diabetes Association. Those wishing further information may contact Piero P. Foa, M.D., Sinai Hospital of Detroit, 6767 West Outer Drive, Detroit 48235.

Medical Assistants Schedule Two Physicians

Major speakers at the Summer Seminar of the Michigan State Medical Assistants Society will include two Michigan physicians. The meeting is scheduled July 26-27 at Mackinac Island.

Donald Wallace, M.D., Pontiac will address the group on the subject of "Aspects of Plastic Surgery" and C. Howard Ross, M.D., retired Ann Arbor doctor, will also have a part in the program.





At left, James D. Fryfogle, M.D., new president of the Wayne County Medical Society. Robert K. Whiteley, M.D., right, is president-elect.

Doctor Fryfogle Takes Helm Of Wayne Society

"I will need the help of medical politicians. I shall ask for it. I shall expect it."

Those were the closing statements by James D. Fryfogle, M.D., as he was installed as the 1968-69 president of the Wayne County Medical Society, June 2.

At the same meeting, Robert K. Whiteley, M.D., was introduced as the new president-elect, and James C. Danforth, Jr., M.D., completed his term of office. The results of the WCMS election of physicians as delegates to the MSMS House of Delegates and as members of the WCMS Council were announced. George L. Reno, M.D., was elected to continue as secretary, and Louis E. Heideman, M.D., to continue as trustee.

Doctor Fryfogle, long active in WCMS and MSMS affairs, told the 120th Annual Meeting that he "hopes to nurture the many small whispers into strong, clear voices for medicine." He challenged the physicians "to recognize the problems in urban medicine and to work towards solutions."

In his comments, Doctor Danforth reported that "the voice of the physician has been heard and is effective in many areas, such as hospitals, ethical standards, third-party payment, health planning, etc." He lauded the WCMS members who actively participate by saying, "without you, our name would be but a sign, and the building would be only a shell."

Orthopedists Summer Meet June 27-28

Eleven Michigan physicians are scheduled to discuss a variety of scientific subjects at the Annual Summer Meeting June 27-28 of the Michigan Orthopedic Society at Hidden Valley Lodge in Gaylord.

Arrangements have been handled by Richard Pomeroy, M.D., president-elect, and George Stilwill, M.D., secretary-treasurer, both of Lansing. H. Ross Hume, M.D., Detroit, is president of the society.

Friday morning speakers and topics are Herbert Kauffer, M.D., Ann Arbor, "The Mechanical Function of the Patella"; John Esslinger, M.D., Birmingham, "Factors in Extractors"; Peter Shifrin, M.D., Royal Oak, "Supracondrylar Fractures of the Femur — Open Reduction"; Kenneth Young, M.D., James MacDonell, M.D., both of Grand Rapids, "Malignant Tumors of the Extremities Requiring Amputation in the Juvenile — Report of 60 Cases," and Richard Ruda, M.D., and Harold Frost, M.D., both of Detroit, "Lengthening of the Posterior Tibial Tendon in the Spastic Four-Foot Abductor."

Saturday morning topics include "Idiopathic Scoliosis — The Milwaukee Brace," by L. S. Mathews, M.D., and Doctor Kauffer, both of Ann Arbor; "Myelodysplasia — A Team Problem," by Frederick Fischer, M.D., Detroit; "Surgical Correction of Rocker-bottom Flatfoot Spastics," by Wallace Johnson, M.D., and Doctor Frost, Detroit; "Epiphyseal Metaphyseal Displasia," by Doctor Esslinger and "Surgery in Cerebral Palsy," by William Blodgett, M.D., of Detroit.



The MSMS position on the need for more medical students has been expressed by legislators, physicians and MSMS staff members many times this summer at the Michigan Capitol Building. This photo of the Capitol Building is one of a series taken by Detroit Photographer Allen Stross for the U.S. government photo series of historic American buildings.

Osteopathic College Fate In Hands of House of Representatives

BY M. A. RILEY
MSMS LEGISLATIVE COUNSEL

The Michigan House of Representatives, which took the first searching look at the proposal to create a state college for training osteopaths, apparently can also have "the last word" in the Legislature.

In early May the House had placed before it a surprise version of House Bill 2196, drafted by a small subcommittee of its Appropriations Committee. An original bill calling for an "osteopathic college authority" arrived on the floor revised to call for a new and completely autonomous state institution of higher learning.

The revised HB 2196 made no pretense to be anything other than a law establishing, at once, an independent college. It was sent to the full House of Representatives almost before the ink was dry, and it sparked lengthy and at times heated debate. Over the objections of forty-one Representatives, an amendment was added by fifty-nine members (14 Democrats joining 45 Republicans) to state that "This act shall not become effective until this school is assigned by the state board of education as an affiliate college to an established state university authorized to grant baccalaureate degrees."

KEY WORD 'AFFILIATE'

This amendment was vigorously – and unsuccessfully – opposed by the backers of the bill. Obviously, the "key" word in the amendment is *affiliate,* which means "associate or unite as a member or branch of a larger or principal body." A clear majority of the House of Representatives demanded governance over any such school by a larger, established university.

Thus amended, 78 of the 110

House members voted the bill over to the State Senate for further consideration, with 25 Representatives still refusing to start a new college at this time, whether it is independent or not.

In the State Senate, three weeks later, the Appropriations Committee of that body, while striking a requested $200,000 from the Governor's budget to encourage expansion of the MSU two-year medical program, also used an osteopathic "college authority" bill as the basis for recommending a new state school of osteopathy. As has been reported, 27 of the 38 Senators approved the Senate version *after* adding a recommended $200,000 to the osteopathic college bill to commence its implementation.

The Senate went a step further than the House: it demanded that the State Board of Education "assign" the DO school to Wayne State University, as an "affiliate," on or before March 31, 1970. However, the chief proponent of the osteopathic college bill told the Senate that the school would be attached to Wayne "for the Degree only" — that the bill's backers intend the new school to be created whether the State Board of Education acts or not — and that it is also intended that the affairs of the new school will be run by its own Board of Control, *not* by Wayne State University.

SENATE, HOUSE DIFFER

Senate Bill No. 70 must be passed by the House of Representatives if it is to be presented to the Governor. On the other hand, if the Senate now passes the House Bill (HB 2196), that bill cannot go to the Governor unless the House of Representatives agrees to any changes made in it by the Senate. And it appears that the Senate wants an osteopathic college which is independent and self-governing, whereas the House does not! In this situation of clear differences, something has got to give.

There are 110 State Representatives and thus 56 are a majority. Fifty-nine amended HB 2196 in the House, and others not present at the time would have joined them.

Since the House of Representatives still has a say in this matter, it now remains to be seen whether the Senate can work its will on the House and force a bill to Governor Milliken's desk providing what its Senate backers so outspokenly say they want — an osteopathic college with its own Board of Control taking no academic or administrative direction from anyone, but having the right to place the name of a major State University on its degrees!

IF PROPOSAL PASSES

If the Senate *does* force this proposal upon the House of Representatives, every interested and concerned citizen will be left with but one recourse — contact with Michigan's Chief Executive — who has already urged the development of academic programs in our present excellent medical schools which would make available many more osteopathic degree opportunities than can ever be created at a separate, infant college which still lacks its first classroom!

The millions upon millions of dollars that the State of Michigan would be committing to classroom, clinical, hospital, parking, student center, library, auditorium and related facilities in now-empty land outside of Pontiac could instead be devoted to shortening the period of time in which the medical schools we already have can commence graduating nearly *double* their present number of physicians — and offering every student the option of either a Doctor of Medicine or a Doctor of Osteopathy degree.

TURN PAGE FOR TALLY
OF LEGISLATOR'S VOTES

Half-page statements in the leading Michigan daily newspapers are helping to present the MSMS position on medical education to the public.

The statements represent another MSMS effort to inform the public about (1) the need to expand the three present medical schools, (2) the optional degree approach to providing education for osteopaths, and (3) the need to repeal the basic science examination.

The statements June 22 in the *Detroit News*, *Detroit Free Press*, *Lansing State Journal*, *Grand Rapids Press*, *Pontiac Press*, and other papers were authorized as part of a many-pronged educational effort this summer.

Physicians are urged to post the statements in their offices and to discuss the three matters with their patients. Patients, physicians, labor leaders, educators and others are being invited to contact their legislators and the governor re SB 70 and HB 2196.

Here's How the Michigan State House of Representatives Voted, on May 5, 1969, on the Question of an Independent Osteopathic College

The House Will Have Yet Another Opportunity to Express Itself

Voting FOR an amendment to place the proposed osteopathic college UNDER the elected governing body of a major state university:

Allen, Richard J.	Ithaca	Mrozowski, Ted	Hamtramck
Anderson, Loren D.	Pontiac	Payant, John D.	Kingsford
Baker, Raymond L.	Farmington	Pilch, Alex	Dearborn
Ballenger, William S.	Ovid	Pittenger, Philip	Lansing
Bennett, John D.	Detroit	*Powell, Stanley M.	Ionia
*Bishop, Donald E.	Rochester	Rohlfs, Harry E.	Akron
*Brennan, Bert C.	Saginaw	*Root, Edson V., Jr.	Bangor
*Brown, James	Okemos	Serotkin, David M.	Mt. Clemens
Brown, Thomas L.	Lansing	Sharpe, Thomas G.	Howell
*Cooper, Daniel S.	Oak Park	Sietsema, Jelt	Grand Rapids
Copeland, William R.	Wyandotte	Smart, Clifford H.	Walled Lake
*Davis, Robert W.	St. Ignace	*Smit, Raymond J.	Ann Arbor
Davis, Stanley J.	Grand Rapids	Smith, James F.	Davison
DelRio, James	Detroit	Smith, Roy	Ypsilanti
*DeStigter, Melvin	Hudsonville	Spencer, Roy	Attica
Dively, Michael A.	Traverse City	Stempien, Marvin R.	Livonia
*Farnsworth, James	Plainwell	*Stites, Robert C.	Manitou Beach
Faxon, Jack	Detroit	Strang, DeForrest	Sturgis
*Folks, James N.	Horton	*Strange, Russell H.	Mt. Pleasant
Ford, Thomas G., Sr.	Grand Rapids	Swallow, Joseph P.	Alpena
*Geerlings, Edgar A.	Muskegon	Tierney, James	Garden City
Groat, Gustave J., Sr.	Battle Creek	*Tisdale, Nelson G.	Midland
Hampton, William P.	Birmingham	*Traxler, J. Robert	Bay City
*Hasper, Gerrit C.	Muskegon	*Varnum, Charles H.	Manistique
Hayward, William	Royal Oak	*Waldron, Robert E.	Grosse Pointe
Heinze, James H.	Battle Creek	*Weber, William V.	Kalamazoo
Hoffman, Quincy	Applegate	*Yeager, Weldon O.	Detroit
*Jowett, William L.	Port Huron	Young, Richard A.	Dearborn Heights
Kramer, Albert A.	Oak Park	*Ziegler, Hal W.	Jackson
Mittan, Ray C.	Benton Harbor		

*=indicates that the Representative *also voted NO* on the osteopathic college bill itself. NOTE: also voting *NO* on the bill were: Smeekens, John P., Sherwood; and Mahalak, Edward E., Romulus.

Absent, or not voting, on the question of placing any osteopathic college under the control of a major university were:

Buth, Martin D.	Comstock Park	McNeeley, Matthew	Detroit
Cawthorne, Dennis O.	Manistee	*O'Neill, James, Jr.	Saginaw
Clark, Harold B.	Warren	Prescott, George A.	Tawas City
*Kelsey, John T.	Warren	Ryan, William	Detroit
Mahoney, Robert D.	Detroit	Suski, Edward	Flint

*=voted *for* HB 2196 *after* it was amended.

All State Representatives whose names are not listed above voted *against* the amendment and thus took a position favoring a self-controlling, autonomous osteopathic school.

Coller-Penberthy-Thirlby Program Set July 24-25

A full scientific and social program, with emphasis on the scientific, is scheduled for the 49th Annual Coller-Penberthy-Thirlby Medical Conference set this year at the Park Place Motor Inn in Traverse City July 24-25.

Robben Wright Fleming, L.L.B., L.L.D., President of the University of Michigan, will be keynote speaker, delivering a talk following dinner on the 24th. Among the honored guests will be James J. Lightbody, M.D., Detroit, president of MSMS. William N. Hubbard, Jr., M.D., dean of the U-M Medical School, will be toastmaster.

A total of 27 scientific discussions are planned during the day-and-a-half program by Chairman A. James French, M.D., Ann Arbor. James W. Hall, M.D., Traverse City, is chairman of arrangements. Hosts for the meeting are the medical and administrative staffs of Munson Medical Center of Traverse City.

Activities included in the two-day schedule of events include a luncheon and fashion show for the ladies at the Traverse City Golf and Country Club, scene also of the conference Golf Tournament for men and women. Swimming at the large indoor pool at the Park Place Motor Inn and nearby fishing spots will also be available.

On the committee are Clifford D. Benson, M.D., Detroit; Doctor Hubbard; Thurston Thieme, M.D., and Harry Towsley, M.D., of Ann Arbor, and William A. Fishbeck, M.D., Richard L. Thirlby, M.D., Philip K. Wiley, M.D. and Maurice S. Pelto, M.D., all of Traverse City.

JOHN HANNAH PRAISES M.D. VOLUNTEERS

* * *

Applauding the nation's physicians now for their service in Vietnam is John A. Hannah, former MSU president, in his new role as AID administrator in Washington.

Recently when the 600th physician signed for a two-months' tour of duty, Mr. Hannah said: "When they (volunteer physicians) have finished their tours of unselfish service they will be able to look back on the experience with pride and satisfaction. They will have expressed in a tangible way the interest of the American people in the ill and the injured Vietnamese civilians."

* * *

Otolaryngologists Elect Officers

New president of the Detroit Oto-Laryngological Society is Richard R. Royer, M.D., Detroit. Other new officers of the organization, which meets the third Thursday of each month at the Wayne County Medical Society headquarters, are James T. Mimura, M.D., Birmingham, president-elect, and Frank Ritter, M.D., Ann Arbor, secretary-treasurer.

Cancer-Inhibiting Chemicals Found By MSU Scientists

Michigan State University biophysicists Barnett Rosenberg and Loretta Van Camp have announced that certain platinum compounds inhibit leukemia and other types of cancers in mice.

The chemicals whose ability to halt cell division was only accidentally discovered by the MSU scientists, will undergo further testing by the National Cancer Institute and should be ready for first clinical tests on human beings about October.

MASTER PHYSICIANS TO BE STUDIED

A better way for doctors to attain the artistic skill of clinical judgment is being sought by three Michigan State University College of Human Medicine faculty members.

Hilliard Jason, M.D., Lee S. Shulman, M.D., and Arthur S. Elstein, M.D., and co-researchers plan to bring master physicians to the campus to observe, record on video tape and analyze the process by which the masters sense, study and solve diagnostic problems.

The expectation of the three-year "Project Medical Inquiry," sponsored by a National Institutes of Health grant which will total $300,000, is that once these problem-solving skills are identified and understood, the researchers will be able to devise ways of teaching them to medical students quickly and efficiently.

Doctor Green MHA President

Edward W. Green, M.D., Detroit, director of the cardiovascular department at Children's Hospital of Michigan, is new president of the Michigan Heart Association.

Doctor Green, who also is an associate professor of pediatrics at Wayne State University School of Medicine, succeeds Michael C. Kozonis, M.D., Detroit. His term with the United Foundation agency is for one year.

EMERGENCY PHYSICIANS BEGIN QUARTERLY MEETINGS

The American College of Emergency Physicians will hold the first in its new schedule of quarterly meetings on June 28 at the Metropolitan Hotel at the Detroit Metropolitan Airport.

CHILDREN START SMOKING YOUNG

The Youth Advisory Council of the Michigan Youth Commission has discovered, after interviewing 951 youths between the ages of 10 and 15, that over half of the children 9 to 12 years of age begin smoking.

According to the results of the survey released late in April ten percent said they started smoking by the time they were six years old.

Saginaw Society Forms Foundation, Helps Med Students

Doctors in Saginaw County will provide assistance for deserving young people interested in careers in medicine.

The Saginaw County Medical Society has formed the Saginaw County Medical Foundation and provided $25,000 in initial funds to be used for student loans. The plan has been announced by Edward F. Kickham, M.D., Saginaw County Medical Society president, and Clyde P. Davenport, M.D., chairman of the Society's committee which planned the foundation.

The Foundation will accept contributions from the public or charitable organizations to enlarge the student loan fund. They will be solicitating for funds. Loans from the fund will be restricted to Saginaw county students.

The Foundation is a memorial to Saginaw county physicians who have died.

Last Reminder For Certificates Of Commendation

The House of Delegates Committee on Certificates of Commendation reminds all component county medical societies to nominate one or more candidates for the MSMS award before the July 1 deadline.

The 1961 House of Delegates, in approving the Certificates of Commendation for the first time, pointed out that the new award "may include both scientific and/or public service and may be awarded to one or more physicians annually who distinguish themselves in the medical profession."

The Committee has set the July 1 deadline for nominations to be presented at the MSMS Annual Session in Detroit in September. The first notice was mailed April 23. The biographic forms sent then to county societies are to be mailed to The Committee on Certificates of Commendation, MSMS, Box 152, East Lansing 48823.

Names of the 1968 recipients are A. Fleming Barbour, M.D., Flint; H. L. Clark, M.D., Ludington; J. M. Dorsey, M.D., Detroit; F. C. Sabin, M.D., Marquette, and W. D. Towsley, M.D., Midland.

Council To Meet In Midsummer

The Midsummer Session of The MSMS Council is scheduled concurrently this year with the Midsummer Meetings of Medical and Health Organizations of Michigan at Boyne Mountain Lodge, Boyne Falls, July 31-Aug. 2.

Quackery Exhibit Visits Ann Arbor

MSMS's large, public service exhibit on quackery has just finished a stay in Ann Arbor where it was on display June 6-12 at the 22nd Annual Conference on Aging sponsored by the University of Michigan and Wayne State University at the Michigan Union.

Michigan Medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in November and December; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00. Printed in USA. All communications should be addressed to the Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

© 1969 Michigan State Medical Society.
Phone: Area Code 517, 337-1351.

Second Class Postage Paid at East Lansing, Mich. and at additional mailing offices.

NATL LIBRARY OF MED
8600 WISCONSIN AVE
BETHESDA MD 20014

BOUND BY
HNM
FEB 2 3 1970

NATIONAL LIBRARY OF MEDICINE
NLM 03493626 7